In the Matter of an Arbitration

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

(the "OMA")

- AND -

MINISTRY OF HEALTH

(the "MOH")

(together, "the PARTIES")

YEAR 1 ARBITRATION BRIEF OF THE ONTARIO MEDICAL ASSOCIATION

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PART ONE - INTRODUCTION AND OVERVIEW

1. This arbitration brief contains the submissions of the Ontario Medical Association ("OMA") in support of its proposal for Year 1 price/compensation ("price") increases under the 2024-28 Physician Services Agreement ("PSA").

2. Part One, in addition to outlining the contents of this Brief, provides an overview of the OMA's Year 1 proposal.

3. Part Two of the Brief highlights some of the many challenges that both physicians and our health care system are facing today, including delayed care and extended wait times, an acknowledged and demonstrable crisis in both family and emergency medicine, as well as in many specialties, an additional physician workload due to such factors as increased patient complexity, a growing administrative burden and workload on physicians, physician burnout and an overall crisis in physician human resources.

4. Parts Three and Four summarize the Binding Arbitration Framework ("BAF") under which this Year 1 arbitration is taking place, as well as the criteria for this arbitration.

5. Part Five provides an historical overview of OMA and Ministry of Health ("MOH" or the "Ministry") bargaining and resulting Physician Services Agreements ("PSA"), demonstrating the extent to which the Year 1 increase must include catchup and redress for past years. Since 2012, as a result of unilaterally imposed fee freezes and fee reductions, physician fee and compensation increases have fallen well behind both inflation and key comparators. Part Five also includes a discussion of the impact of the bargaining constraints and climate when the 2021 PSA was concluded, resulting in the the limited fee increases contained in the 2021-24 PSA. As this Board of Arbitration is well aware, Bill 124 substantially restricted compensation increases for employees across the health care and broader public sector (despite the impact of the pandemic and rising inflation). Although Bill 124 was subsequently struck down as being unconstitutional, physicians have yet to see any consequential increases that other groups in the health care sector and elsewhere have achieved, nor any protection against the inflationary increases that affected both the relative value of the fees and other payments they

receive, but also the costs of practice they face. Redress for the very real impact of Bill 124 on the 2021-24 PSA is an important component of the Year 1 increase being sought by the OMA.

6. Part Six is a summary of Ontario's economic and fiscal position since 2021, while Part Seven details the physician recruitment and retention crisis Ontario now faces.

7. Parts Eight and Nine then contain the OMA's submissions in support of its specific Year 1 proposal in two sections. Part Eight, Section B addresses the OMA's claim for 10.2% catch-up based upon the review of the history of bargaining since 2012 including the impact of Bill 124.

8. Part Eight, Section C and Part Nine outline the OMA's submissions in support of its 12.7% Year 1 increase (separate and apart from the claim for catch-up). More specifically, Section C contains the OMA submissions for a 5% Year 1 general increase, and Part Nine then outlines the various areas in which the OMA seeks additional Year 1 targeted increases of 7.7%, increases which are required and justified by the urgent need for funding support and investments in a range of essential physician services critical to providing necessary medical care to the people of Ontario.

9. As this Arbitration Board ("Board") is aware, under the February 2024 Implementation and Procedural Agreement[1] (the "Procedural Agreement"), the OMA and the Ministry have agreed to address the issue of price increases for the 2024-28 PSA in at least two phases.

10. The first phase requires that the Board determine the overall price increase for Year 1 of the 2024-28 PSA. From the OMA's perspective, this will include consideration and determination of:

(a) the OMA's claim for redress or catch-up resulting from the relatively low level of price increases received by Ontario physicians dating back to 2012

[1] Ontario Medical Association and the Ministry of Health February 2024 Implementation and Procedural Agreement (the "Procedural Agreement"), TAB 1 OMA Book of Documents ["BOD"] VOL 1.

and, more recently, the impact that restrictions imposed under the now unconstitutional Bill 124 had on price increases under the 2021-24 PSA, including price increases to reflect inflation and, in addition,

(b) the OMA's claim for a normative price increase for 2024-25. This includes both an appropriate general price as well as additional targeted funding to address a variety of critical areas, as outlined more fully below.

11. Furthermore, under the Procedural Agreement, 30% of the overall Year 1 increase will be allocated to targeted price or compensation increases. The Procedural Agreement also contemplates that, after the Year 1 award, the parties will engage in focused bilateral negotiations and mediation over the Year 2, 3 and 4 price increases, over how to allocate the awarded price increases to each specialty or group of physicians as between across the board ("ATB") and relativity-based allocation, and over the allocation of the amount awarded for targeted increases for Year 1. Any unresolved issues will subsequently be determined by this board through final and binding arbitration.

12. The OMA is proposing a 22.9% increase for Year 1. This is comprised of the following elements:

(a) A 10.2% increase in respect of catch-up, based on the following factors:

(i) recognition and redress for the impact of inflation on the cost of living and physicians' cost of practice;

(ii) recognition and redress for the increases received by other groups including those in the Ontario health and broader public sectors for the period during which physician compensation was constrained by Bill 124; and

(iii) recognition and redress for the low price increases received by physicians since 2012 relative to the increases received by others in the Ontario health and broader public sector, and having regard to

the increases to the costs of living and the cost of practice since 2012.

(a) A normative increase for year one of 12.7%, consisting of the following:

(i) 5% general price increase for 2024-25 (to be allocated to each section or physician grouping as the parties agree, or failing agreement, as this Board determines), and to be applied to the OHIP Schedule of Benefits (the "OHIP Schedule") and flow-through to other elements of physician compensation under the Binding Arbitration Framework ("BAF"); and

(ii) 7.7% to provide for additional targeted funding for 2024-25, reflecting the imperative to invest in various targeted physician-related health care system initiatives.

PART TWO - THE OMA, ITS MEMBERS, AND THE CHALLENGE OF BEING A PHYSICIAN IN THE FACE OF A HEALTH CARE SYSTEM IN CRISIS

A. BACKGROUND TO THE OMA AND ITS MEMBERS

13. As of April 1, 2024, the OMA represents Ontario's 48,795 physicians, medical students, and retired physicians. Of these, 35,527 are actively practicing.[2] Approximately 12.6% of OMA members are just starting their careers, 40.4% are established in their careers, and 19.9% are late career. 55.9% are men and 44.1% are women. The OMA's members can be found throughout all regions of the province including in urban, rural and Northern communities.

14. The OMA members practice in all areas and specialties. OMA members belong to sections with a member's primary section being the section most relevant to their area of practice, while the secondary section is a secondary or additional area of practice. The breakdown of OMA by section is set out in the following table:

Number of Members by Section

As of April 1, 2024

Section	Primary	Secondary	Total
Addiction Medicine	214	533	747
Allergy and Clinical Immunology	210	156	366
Cardiac Surgery	102	4	106
Cardiology	848	93	941
Chronic Pain	315	483	798
Critical Care Medicine	410	413	823
Dermatology	310	12	322
Diagnostic Imaging	1,312	76	1,388

[2] OMA, Membership Data as of April 1, 2024, TAB 2 Book of Documents ("BOD") VOL 1.

Emergency Medicine	2,056	1,208	3,264
Endocrinology and Metabolism	342	78	420
Eye Physicians and Surgeons of Ontario	592	2	594
Gastroenterology	466	147	613
General & Family Practice	16,188	1,815	18,003
General Internal Medicine	1,456	1,495	2,951
General Surgery	1,004	78	1,082
General Thoracic Surgery	71	32	103
Genetics	68	8	76
Geriatric Medicine	180	24	204
Haematology & Medical Oncology	660	206	866
Hospital Medicine	469	762	1,231
Infectious Diseases	235	119	354
Laboratory Medicine	798	50	848
Long Term Care/Care of the Elderly	156	370	526
Medical Students	2,538	160	2,698
Nephrology	323	93	416
Neurology	638	120	758
Neuroradiology	96	37	133
Neurosurgery	134	4	138
Nuclear Medicine	83	94	177
Obstetrics & Gynaecology	1,107	65	1,172

Occupational & Environmental Medicine	114	267	381
Ontario's Anesthesiologists, A section of the OMA	1,797	208	2,005
Orthopaedic Surgery	739	7	746
Otolaryngology - Head and Neck Surgery	359	2	361
Palliative Medicine	343	689	1,032
Pediatrics Section OMA	1,848	199	2,047
Physical Medicine & Rehabilitation	312	95	407
Plastic Surgery	304	1	305
Primary Care Mental Health	283	486	769
Psychiatry	2,844	22	2,866
Public Health Physicians	207	211	418
Radiation Oncology	269	2	271
Reproductive Biology	62	34	96
Residents	2,520	765	3,285
Respiratory Disease	396	185	581
Rheumatology	322	127	449
Sport and Exercise Medicine	181	526	707
Urology	385	1	386
Vascular Surgery	125	12	137
Grand Total	**46,791**	**12,576**	**59,367**

15. The OMA’s members are the most highly trained and skilled medical professionals in the province. The path to becoming a doctor in Ontario is long and arduous and requires

many years of intensive study, attracting some of the very best and brightest in the province.

16. The majority of applicants to Canadian medical schools have at a minimum a bachelor's degree with some even holding advanced degrees. All applicants must complete undergraduate courses in mathematics, biology, English, physics and chemistry before applying to medical school. MCAT or Medical College Admission Test scores are required for also admission to some of Ontario's medical schools.

17. Students attend medical school for four years (three years at McMaster). The first two years are typically spent in classrooms and laboratories and the final two years are spent in practicums working with patients while being supervised by senior physicians within clinic and hospital settings. During this time, student physicians rotate through psychiatry, family practice, internal medicine, pediatrics, surgery, obstetrics and gynecology.

18. Following medical school, graduates participate in residency programs, which can last between 2 to 8 years, depending on the specialty. In some cases, additional fellowships or subspecialty training is needed to obtain even more specialized training needed to be able to practice in the physician's specialty or sub-specialty. As well, following their residency, all physicians must pass a standardized licensure examination. For internationally trained physicians, there are different but equally if not more rigorous pathways to licensure.

19. As set out below, physicians in Ontario are increasingly being called up to work in stressful and difficult circumstances in a health care system in crisis.

B. CHALLENGE OF BEING A DOCTOR TODAY

20. Physicians in Ontario today must work within a health care system that is in crisis, with patients facing delays in receiving care due to overwhelming demand and insufficient resources as well as extended wait times for many diagnostic, surgical and other procedures, where there is increased patient complexity (both physical and mental),

where millions of patients are without family doctors, and where there are shuttered emergency rooms, to give but a few examples. Doctors' remuneration has not kept pace with inflation and the rising costs of their practice, they face a growing administrative burden compounded by the growing scope of practice of other health professionals, and they have endured the unprecedented challenge of the COVID-19 pandemic which has added to the rate and extent of physician burnout, and exacerbated recruitment and retention issues. Physicians see others in the health care and broader public sector, including the hospital sector, negotiating or arbitrating to receive significant compensation increases while they fall further and further behind. As set out below, Ontario physicians have also increasingly seen a relative decline in the value of their services and their net compensation compared to physicians in other provinces. The OMA's Year 1 Compensation Increase proposal must be understood and assessed within this broader context.

I. Delayed Care and Wait Times

21. Delays and long-wait times can be found throughout the system. As of April 2024, as set out in the following chart based on Ontario Health data, wait lists for all surgeries have grown to well over 186,000. This backlog has more than doubled since the pre-pandemic period, and the problem is only getting worse. These delays "expose patients to higher risks of poorer health-related quality of life, progression of underlying conditions and worse surgical outcomes."[3]

Service Area	Wait List	Wait List Over Target	# Wait list Over Target	Wait List over Target (Previous Week)		% Change Wait List Over Target vs. Previous Week	% Wait List Over Target (Pre-pandemic)
All Surgery	186,745	71,260	38%	72,389	↓	-1.6%	18%
General Surgery	20,458	6,972	34%	6,982	↓	-0.1%	11%

[3] N. Jaworska, Emma Schalm et al. "The impact of delayed nonurgent surgery during the COVID-19 pandemic on surgeons in Alberta: a qualitative interview study" CMAJ Open, Jul 2023, 11 (4) E587-E596; DOI: 10.9778/cmajo.20220188, TAB 3 BOD VOL 1.

Gynaecologic Surgery	16,562	6.494	39%	6,579	↓	-1.3%	12%
Neurosurgery	1,758	939	53%	935	↑	0.4%	22%
Oncology Procedures	5,783	1,573	27%	1,680	↓	-6.4%	10%
Ophthalmic Surgery	45,653	15,169	33%	15,567	↓	-2.6%	17%
Oral and Maxillofacial Surgery and Dentistry	2,568	1,109	43%	1,139	↓	-2.6%	23%
Orthopedic Surgery	45,031	16,466	37%	16,726	↓	-1.6%	24%
Otolaryngic Surgery	10,819	4,861	45%	4,894	↓	-0.7%	20%
Plastic and Reconstructive Surgery	6,273	3,015	48%	3,078	↓	-2.0%	20%
Thoracic Surgery	507	216	43%	222	↓	-2.7%	17%
Urologic Surgery	9.217	3,296	26%	3,349	↓	-1.6%	11%
Vascular Surgery	2.145	1,116	52%	1,137	↓	-1.8%	27%

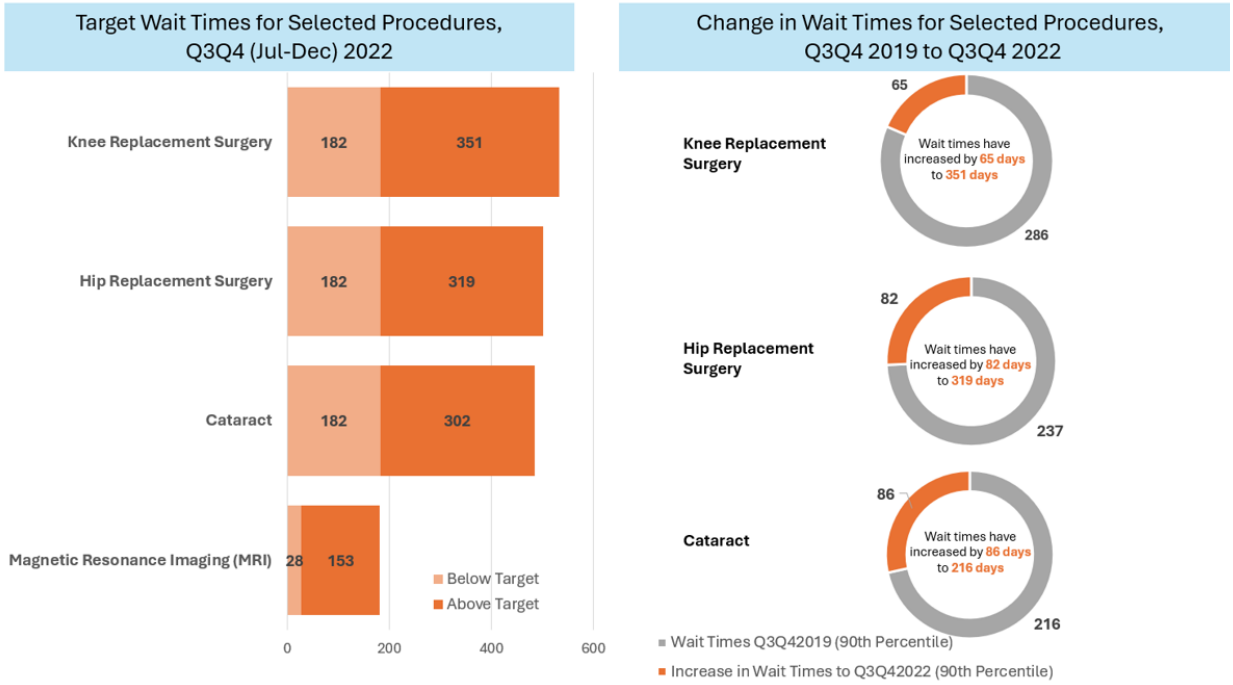
22. As well, according to Ontario Health Quality reports, as of February 2024, only 34% of patients were able to receive an MRI within the provincial target time.[4]

23. In another very troubling example, Ontario Health Quality reports that only 59% of prostate cancer patients were able to receive a referral to a first clinician appointment within the provincial target timeframe, and then only 66% of them were able to have the actual prostate cancer surgery within the provincial target timeframe.[5]

24. As the following chart shows, wait times have become universally longer in the post-pandemic era (for example, increasing between 65 and 86 days for knee, hip, and cataract procedures between 2019 and 2022):

[4] Ontario Health, Wait Times MRI, February 2024, TAB 4 BOD VOL 1.
[5] Ontario Health, Wait Times Prostate Cancers (Time from Referral to First Clinician Appointment (Wait 1) and (Time from Decision to Surgery (Wait 2) October 2023-December 2023, TAB 5 BOD VOL 1.

Change in Wait Times for Selected Priority Procedures, Q3Q4 2022 vs Q3Q4 2019, Ontario



Source: Canadian Institute for Health Information ("CIHI"), Wait times for priority procedures in Canada. Published April 4, 2024.

25. Delays and the lack of resources to enable physicians to provide much needed mental health services abound. For example, Children's Mental Health Ontario indicates that there are 28,000+ children and youth waiting for community mental health care. Wait times could be as long as 2.5 years for some specialized services.[6]

26. Waitlists are also endemic in the long-term care ("LTC") sector. According to the Ontario Long-Term Care Association more than 43,000 people are waiting for long-term care, a waitlist that has nearly doubled over the past 10 years and is expected to grow by 1,000 people per year, reaching 48,000 by 2029.[7] As well, many patients also face unduly long wait-times for home care, during which their health deteriorates. All of this in turn leads to increased pressure and workload on physicians, as well as what might otherwise

[6] Children's Mental Health Ontario (CMHO), "#KidsCantWait Our Election Ask", TAB 6 BOD VOL 1.
[7] Ontario Long Term Care Home Association, "The Data: Long-Term Care in Ontario" TAB 7 BOD VOL 1.

be avoidable Emergency Room visits or hospital admissions, which adds pressure to the system in other areas.

27. There are also very long waitlists to see specialists. Moreover, family doctors themselves have no way of easily referring their patients to the specialist with the shortest wait time in their area, meaning patients often wait longer than necessary. As well, referring patients to specialists is itself a cumbersome, manual process that increases administrative workload. Information on wait times and care specialties is not readily available, and intake forms are different from specialist to specialist and hospital to hospital.

II. Family Medicine

28. The evidence of a crisis in the health care system is particularly stark in family medicine.[8] At present, 2.3 million patients do not have a regular family physician in Ontario, an increase from 1.6 million in 2017 and a number which is expected to almost double by 2026.[9] The lack of a family physician can have very serious health consequences for patients in obtaining initial diagnosis and follow-up care when ill and in receiving regular preventative care. This, in turn, results in increased pressures on physicians and the health care system generally.[10]

29. As reflected by the large and growing number of unattached patients, and as set out in more detail under the discussion of recruitment and retention below, there is a severe shortage of family physicians in Ontario. With only one family physician per 1,000 people, Ontario has one of the lowest family physician to population ratios in the entire

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[8] Stuart Foxman, Colleges of Physicians and Surgeons Ontario, "Family Medicine in Crisis," *Dialogue* (June 15, 2023) ["Foxman"], TAB 8 BOD VOL 1.
[9] Jaakkimainen L, Bayoumi I, Glazier RH, Premji K, Kiran T, Khan S, Frymire E, and Green ME. "Development and validation of an algorithm using health administrative data to define patient attachment to primary care providers". 2021, Journal of Health Organization and Management Vol. 35 No. 6, 2021 pp. 733-743, TAB 9 BOD VOL 1.
[10] Danielle Martin, "The Primacy of Primary Care," Temerty Medicine, University of Toronto (April 11, 2023), TAB 10 BOD VOL 1.

country.[11] Compounding this shortage is the fact that the proportion of family physicians practicing comprehensive longitudinal family medicine is falling.[12] The evidence is that this decline is happening across Canada and in Ontario, and not only for family physicians entering practice but across all career stages.[13]

30. The family physician shortage is further impacted by a growing population and an aging population. As well, increased patient care complexity and a higher prevalence of chronic health issues means that physicians must spend more time on each patient visit, further increasing the demands on an already overwhelmed system.[14]

31. The family medicine crisis is also only going to get worse due to the anticipated retirement of many family physicians. The retirement of a single doctor can leave thousands of patients without a family doctor. According to some estimates between 2019 and 2025, nearly 1.7 million Ontarians have and will need to find a new family doctor because their doctor has retired. Their new doctor, assuming one can be found, will encounter a patient who, themselves has grown older and whose patient complexity has increased.[15]

32. As well, even before a family physician retires, they will typically start reducing their workload on average three years before retirement and many will stop providing comprehensive care,[16] resulting in fewer clinical hours being provided to their patients even before they retire.

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[11] Li K, Frumkin A, Bi WG, et al. "Biopsy of Canada's family physician shortage," *Fam Med Com Health* 2023;11:e002236, pp. 1-4 at p. 2, TAB 11 BOD VOL 1.
[12] Premji K, Green ME, Glazier RH, et al, "Characteristics of patients attached to near-retirement family physicians: a population-based serial cross-sectional study in Ontario" *BMJ Open* 2023;13:e074120, pp 1-9 at p. 1, ("Premji et al") TAB 12 BOD VOL 1.
[13] Lavergne et al, "Declining Comprehensiveness of Services Delivered by Canadian Family Physicians Is Not Driven by Early-Career Physicians, Ann Fam Med. 2023 Mar-Apr; 21(2): 151–156, TAB 13 BOD VOL 1.
[14] *Li, supra* at p. 1, TAB 11 BOD VOL 1.
[15] Flood CM, Thomas B, McGibbon E., "Canada's primary care crisis: Federal government response," *Healthcare Management Forum*, 2023;36(5):327-332 at 327, TAB 14 BOD VOL 1. See also Premji et al, *supra,* TAB 12 BOD VOL 1.
[16] Simkin S, Dahrouge S, Bourgeault IL. End-of-career practice patterns of primary care physicians in Ontario. Can Fam Physician. 2019 May;65(5): e221-e230., TAB 15 BOD VOL 1.

33. It has also been suggested that the clinical hours of work of family physicians are also declining due to demographic changes amongst physicians. For example, late career physicians have much larger rosters than early career physicians. Due to these changing demographics and patterns of practice, it is often the case that more than one family physician is needed to replace each retiring family physician, even before considering the increased demands on the system due to population aging and growth and increased patient complexity.[17]

34. At the same time as more family physicians are retiring, fewer medical students are choosing to practice family medicine. Only 30.3% of students in Canada ranked family medicine as their top choice in 2023, down from 31.4% in 2021 and 38% in 2015.[18] In Ontario, only 29.6% of Ontario students ranked family medicine as their top choice in 2023, down from 40.2% in 2015.

35. As noted above, doctors who choose to continue to practice family medicine face the daily challenges of working in an overwhelmed and increasingly broken system. On the one hand, the complexity of their work has greatly increased as a result of an aging population, increased chronic disease, and the expansion of clinical practice guidelines. On the other hand, their ability to spend time on much-needed clinical work is affected by an overwhelming and continually increasing administrative burden which can amount to up to 19 hours a week.[19]

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[17] OMA Calculations based on OHIP Claims Database, the Corporate Provider Database, and the Architected Payment Database, all maintained by the Ontario Ministry of Health.
[18] Ryan Patrick Jones, "Physicians sound alarm over unfilled Ontario residency spots" *CBC News (*March 24, 2024), TAB 16 BOD VOL 1.
[19] Foxman, *supra,* TAB 8 BOD VOL 1; Ontario College of Family Physicians, "A Profession in Crisis: The survival of family medicine in Ontario" (May 31, 2023), ["OCFP Crisis"], TAB 17 BOD VOL 1. As the OCFP concludes: "Results from the survey conducted on behalf of the Ontario College of Family Physicians, of more than 1,300 family doctors clearly show a full-blown crisis. An alarming number of family doctors – 65 per cent – are preparing to leave the profession or reduce hours in the next five years, reporting that they are overwhelmed with unnecessary administrative work and a lack of support. Already, 2.2 million are without a family doctor. The most recent data also shows 1.7 million Ontarians have a family doctor aged 65 or older who are poised to retire. Adding to the crisis is a clear trend in medical students not choosing family medicine."

36. As well, because of backlogs and bottlenecks elsewhere in the health care system, it is often very difficult to get patients the diagnostic tests or a visit with the specialist that they need, adding strain, workload and time for family physicians concerned about ensuring that their patients get access to necessary quality care.[20]

37. All of this in turn is leading to higher levels of burnout amongst family physicians. According to the Canadian Medical Association's 2021 *National Physician Health Survey,* "The prevalence of burnout is significantly higher among respondents in general practice/family medicine (57%*) compared with physicians practicing in other/administration positions (40%*)."[21] Similarly, according to the OMA's own survey, about 60% of physicians reported symptoms of burnout in 2022, with 10% of those reporting that they were "completely burned out and often wonder if [they] can go on."[22]

III. Emergency Medicine

38. Signs of crisis are also widespread in emergency medicine ("EM"). According to Ontario Health Quality reports, as of February 2024, patients spent an average of 20.5 hours in the emergency department ("ED") before being admitted and getting a bed. This far exceeds the provincial target of 8 hours.[23] This in turn makes it harder to see new patients, slowing workflow for emergency physicians, including taking them longer to complete an assessment for a given patient, in turn increasing wait times. As well, emergency physicians end up being responsible for the care and management of a patient over an extended period of time leading increased stress and burnout in physicians. None of this is captured in bare Ministry statistics, devoid of this clinical on the ground reality.

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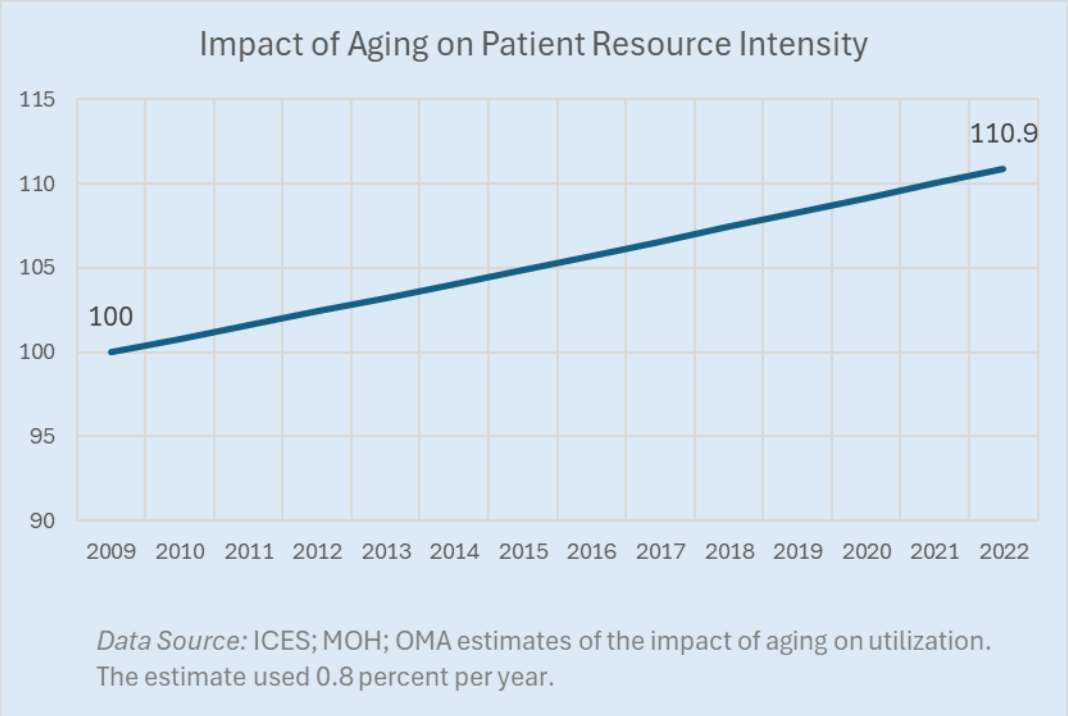
[20] *Ibid.*
[21] Canadian Medical Association, *National Physician Health Survey. 2021,* at p. 17, TAB 18 BOD VOL 1.
[22] Ontario Medical Association, MRAC Prescription for Ontario Survey: demographics of respondents in active practice (February 9, 2023) ("OMA Prescription Survey"), TAB 19 BOD VOL 1.
[23] Health Quality Ontario, "Time Spent in Emergency Departments: Provincial" (February 2024), TAB 20 BOD VOL 1.

39. Shortages of emergency physicians manifest themselves in larger EDs as increases in waiting times to be seen by a doctor ("Physician Initial Assessment" or PIA time). In contrast, these shortages, in smaller hospitals result in closures of the emergency department entirely; these are increasing, with the Ontario Health Coalition reporting that there have been there have been 868 temporary emergency department closures, and 316 urgent care centre closures in smaller communities in 2023 alone.[24]

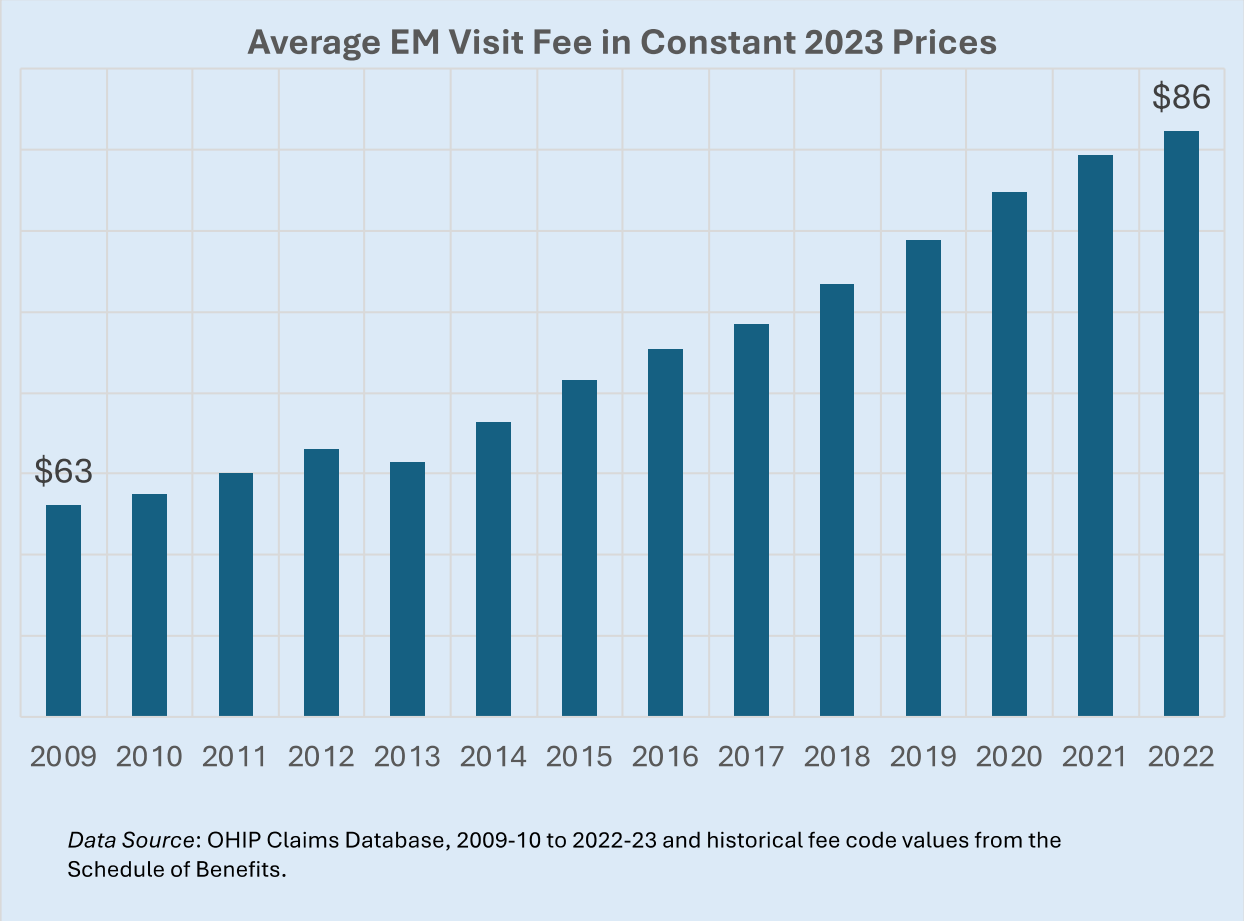
40. As discussed in further detail below, there is also growing evidence of recruitment and retention challenges amongst ED physicians. For example, growth in supply of new EM physicians is now less than 30% of pre-pandemic levels (1.4% vs 5.1%) which is 1% lower than the average for all other specialties. Another worrisome trend is the 76% increase in the attrition rate of EM physicians (2.3% vs 1.3% pre-pandemic).[25] Another indicator of the shortage of EM physicians compared to the need is found in the HFO job posting portal, which advertises vacant permanent physician positions ("jobs available"): the number of positions listed (excluding locums and part-time positions) has risen from 1.3% of the total workforce in Dec 2019 to 4.3% in 2023.[26]

41. Emergency Room physicians are also being asked to deal with increasing patient complexity. As set out in the following chart, the impact of one factor alone, the aging of the population, has increased the resource intensity per patient by approximately 11% since 2009-10:

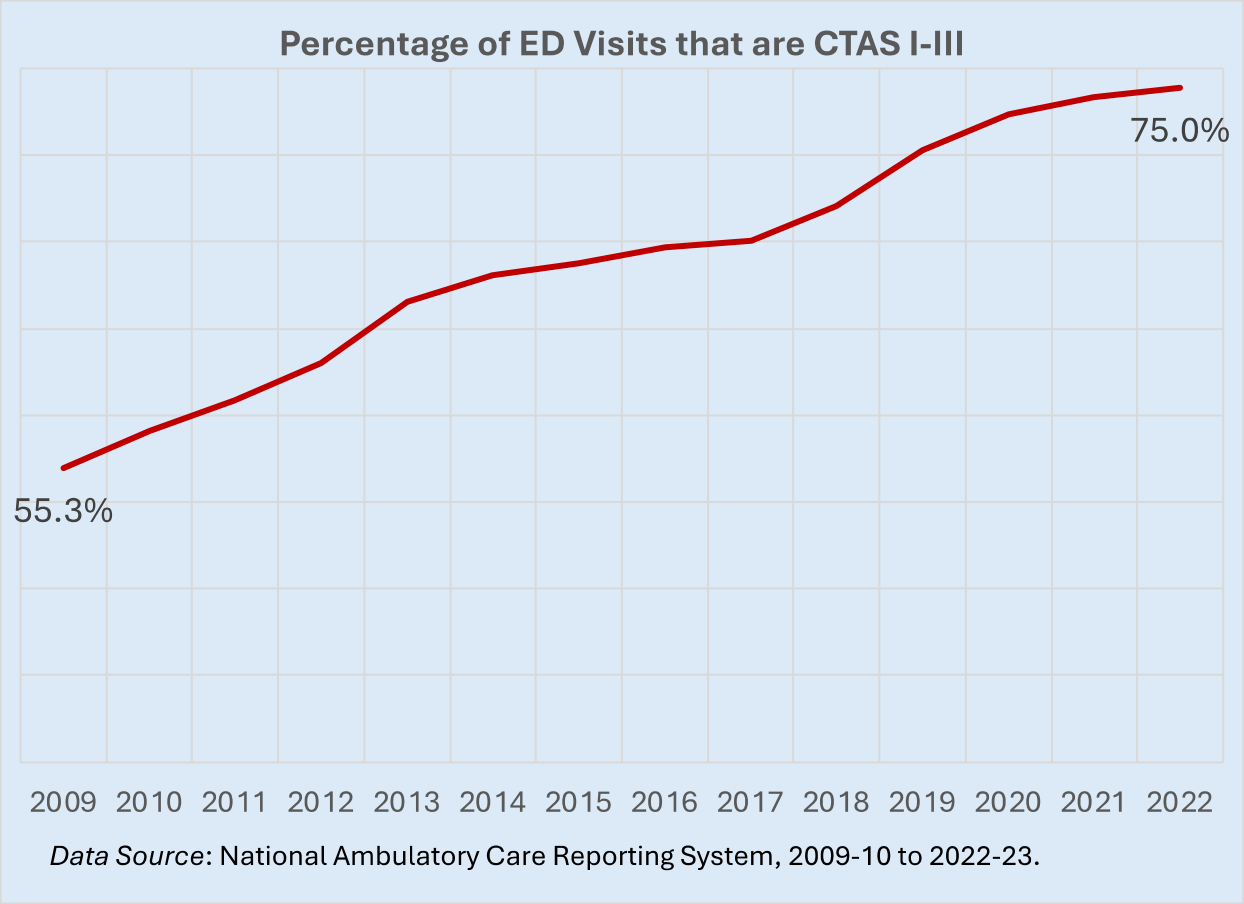
[24] Ontario Health Coalition. Unprecedented and Worsening: Ontario's Local Hospital Closures 2023. (December 4, 2023), TAB 21 BOD VOL 1.
[25] Data Source: Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2022) - Hamilton, ON: OPRC; 2024.
[26] Data Source: Health Force Ontario, 2019 to 2023.



42. This increasing complexity is also evident in the average value of patient visit, in constant April 1, 2023 fee values, which has increased by approximately 37% since 2009-10 (from about $63 per visit in 2009-10 to $86 per visit in 2022-23). This shows that, to the extent that a fee value of service captures time and intensity, physicians provided more time consuming, complex services today than they did in the past.



43. This is also documented in the proportion of higher-acuity ED visits over time, where the percentage of CTAS Levels I-III has increased by approximately 14.7 per centage points, from about 55% for in 2009-10 to about 75% in 2022-23, as set out in following chart:



Data Source: National Ambulatory Care Reporting System, 2009-10 to 2022-23.

44. Stated differently, higher complexity in ED visits requires that each visit today requires approximately 4 minutes longer on average than it did in 2009-10, or about 17% more time (from about 23 minutes per visit in 2009-10 to about 27 minutes per visit in 2022-23), an equivalent to at least 3 patient visits per day. This estimate is based on the Predictors of Workload in the Emergency Room ("POWER") study conducted nearly two decades ago and is most likely a significant underestimate of the impact of this increased complexity on physician's throughput. As a result, the indicated decrease is likely worse than 3 patients per shift. Under the 2021 PSA, a new POWER study is being conducted which will provide updated data.

IV. Increasing Patient Complexity

45. A further challenge facing physicians today is that they are increasingly seeing patients with more complex physical, mental and social needs than was previously the

case. For example, the burden of being unhoused, of drug use and of mental illness is significantly greater and takes more time to address than medical issues alone. Physicians know what to do for heart/lung/etc. issues but having to manage someone who has a substance use disorder and is homeless and who requires ongoing antibiotics creates significant additional workload and challenges, which often fall on physicians.

46. According to a recent study[27] using the Canadian Institute for Health Information ("CIHI") Population Grouper, the prevalence of multiple chronic conditions in Ontario is growing, with 'minor' or 'moderate' conditions slightly declining while 'major' conditions increased. Overall, the age-sex standardized patient resource intensity has increased by about 0.5 percent each year from 2008-09 to 2017-18.

47. Individuals with complex health and social needs also require interprofessional team-based care as the level of support required for them may well be beyond the capacity of family medicine physicians working alone. One study has found that 6.1% of the population of Ontario—approximately 725,500 people—had high comorbidity, but that only 15% of these people were rostered to practices offering interprofessional team-based care. [28] Similarly, data from the Commonwealth Fund suggests that people with high needs often do not have access to the services they need, such as care coordination, emotional counselling, and assistance with managing functional limitations; this is despite having a regular doctor or place of care. In the absence of sufficient support, this workload burden falls the family physician. Moreover, patients with unmet needs are likely to report difficulties in accessing care primary care and are therefore less likely to participate in preventative care and more likely to visit the emergency department.[29]

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[27] Steffler M, Li Y, Weir S, Shaikh S, Murtada F, Wright JG, Kantarevic, J. *Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada*. Canadian Medical Association Journal. 2021 Feb 22;193(8): E270-7., TAB 22 BOD VOL 1.

[28] Jopling S, Wodchis WP, Rayner J*, et al* "Who gets access to an interprofessional team-based primary care programme for patients with complex health and social needs? A cross-sectional analysis" *BMJ Open* 2022;12: e065362. doi: 10.1136/bmjopen-2022-065362, TAB 23 BOD VOL 1.

[29] Jamie Ryan et al., "How High-Need Patients Experience Health Care in the United States" Commonwealth Fund" (December 2016), TAB 24 BOD VOL 1.

48. For physicians on the front lines, increased patient complexity means increased workloads and increased pressures on their already packed clinical schedules alongside their ongoing concerns about ensuring time patient quality of care in an overburdened system.

V. Administrative Burden and Increasing Workload

49. Another challenge that physicians are experiencing is the unprecedented administrative burden that has been added to their already high workloads which, amongst other things, takes away from their ability to provide clinical care. The Ontario College of Family Physicians ("OCFP") found that family physicians spend 19.1 hours per week on administrative work.[30]

50. The OMA recognizes that there are some administrative tasks that add value to the health system and are best done by physicians (e.g., certain forms requiring medical expertise). At the same time, there are many that are redundant, needlessly complicated, not integrated with electronic health records ("EHRs"), and simply unnecessary. As a result, the considerable extra time and complexity added to an already overburdened physician workload could either be eliminated, reduced or better performed by other (currently unavailable) health professional or staff.

51. One family doctor who recently left the profession after 29 years of practice, earlier than she had previously planned, explained that her decision was due to the increasing burden of administrative work. For her, this work amounted to "up to 25 hours per week alone on lab reports, x-ray results, and lately on processing pharmacists' prescriptions," none of which she can bill for and all of which cuts into her clinical time. As she explains "[r]ising costs, inflation and the burden of all this new administrative work has made running a family clinic untenable" and that doctors need to "be paid for the administrative

[30] OCFP Crisis, *supra,* TAB 17 BOD VOL 1.

work we do...[and] the government needs to find a way to reduce that administrative burden." [31]

52. Another family doctor, who is the sole family physician in a small town, reports working more than 65 hours a week and coming into the clinic on weekends to catch up on her paperwork, leaving her feeling "completely and utterly overwhelmed."[32]

53. In a survey focused on Nova Scotia, physicians identified spending 10.6 hours per week on administrative work and estimated that 38% of this work was either unnecessary or could be done by someone other than a physician.[33]

54. Problematically, recent scope of practice changes for pharmacists had added to rather than lessened physician administrative burden. According to the Canadian Foundation for Pharmacy, close to 850,000 MedsCheck reviews were conducted in 2022-23, an increase of over 30% from previous year.[34] The family physician is notified of the results of each completed MedsCheck, including when no issues have been identified. In 2023, this amounted to more than 200,000 notifications to physicians in Ontario which physicians are required to spend countless hours reviewing, filing and potentially follow up on, for no compensation. As a result, physicians are required to spend countless unpaid time reviewing, filing and potentially following up on pharmacists prescribing notifications. Even though the vast majority of these notifications are "normal" and no patient interaction is required by the physician, professional obligations requires them to review and file MedsCheck forms with the patient record. This work is time-consuming, unpaid and often of limited if any clinical value.

55. Similarly, when pharmacists or other professionals administer vaccines, the information must be conveyed to physicians who must manually enter vaccine information

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[31] Cynthia Mulligan, "Paperwork burden driving Ontario family doctor to quit, amid critical GP shortage" *City News Toronto* (February 14, 2024), TAB 25 BOD VOL 1; See also Fan-Wah Mang, as told to Anthony Milton, "I've been a family doctor for more than 20 years. Now, I have no choice but to close my practice," *Toronto Life,* (April 18, 2024), ["*Toronto Life"*] TAB 26 BOD VOL 1.
[32] CPSO, "I Feel Like I am Failing," *Dialogue* (June 15, 2023), TAB 27 BOD VOL 1.
[33] Alchad Alegbeh and Laura Jones, "Patients before paperwork," Canadian Federation of Independent Business (January 2023), ["CFIB Paperwork"] TAB 28, BOD VOL 1.
[34] Canadian Foundation for Pharmacy, "Post-pandemic boom in billable services," TAB 29 BOD VOL 1.

into the patient's electronic medical record so that an accurate medical vaccine record can be maintained. In many cases, the information provided to the physician may be inadequate requiring the doctor to track down the accurate information.

56. In both instances, changes in scope of practice have not been accompanied by appropriate system initiatives such as an integrated system for electronic medical records or a central vaccine registry which would be valuable tools to relieve some of the additional administrative work on physicians arising from scope expansion.

57. Another area of concern is the increasing demand for sick notes (and other reporting forms) which take up valuable clinical time without contributing to patient care and well-being.

58. Furthermore, family physicians are concerned that the administrative burden will grow yet again with the advent of the Ministry of Health's ("MOH") new primary care information exchange ("PCIE") initiative to include primary care data from electronic medical records ("EMRs") into the provincial electronic health record ("EHR"), Despite concerns raised by OMA, the MOH is proceeding to roll out this initiative.

VI. Physician Burnout

59. Burnout is primarily defined as a work-related syndrome characterized by three dimensions: "emotional exhaustion; depersonalization, or feelings of detachment and cynicism toward people and work; and a reduced sense of personal accomplishment."[35] At the personal level, physician burnout has "been associated with increased depression, suicidal ideation, substance use and motor vehicle crashes."[36]

[35] OMA, "Healing the Healers: System-Level Solutions to Physician Burnout," (August 18, 2021) ["OMA Burnout"], TAB 30 BOD VOL 1.
[36] *Ibid*.

60. With a health care system at the breaking point, it should come as no surprise that physicians are also at a breaking point and suffering from increased levels of burnout. These problems predated the pandemic but have only gotten worse since then.[37]

61. In the 2018 National Physician Health Survey conducted by the Canadian Medical Association, nearly one-third of physicians and residents reported high levels of burnout.[38] The 2021 Medscape National Physician Burnout & Suicide Report reported that, for 79% of U.S. physician respondents, burnout began before the start of the COVID-19 pandemic.[39]

62. According to OMA surveys, in March 2020, just prior to the pandemic, 29% of Ontario physicians had high levels of burnout with two-thirds experiencing some level of burnout. By March 2021, these rates had increased, with 34.6% of Ontario physicians reporting high levels of burnout and almost three-quarters reporting some level of burnout. Female physicians and younger physicians were particularly at risk (unweighted results).[40]

63. After weighting survey responses to reflect OMA membership demographics, the overall rate of high levels of burnout among physicians in Ontario increased from 28.0% in 2020 to 34.7% in 2021, a 1-year increase of 6.8 percentage points (weighted results).[41]

64. According to OMA members, the biggest contributors towards burnout are patient expectations/patient accountability, reporting and administrative obligations, health

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[37] CPSO, "Physician Burnout and COVID-19," *Dialogue,* (June 12, 2020), TAB 31 BOD VOL 1.
[38] Canadian Medical Association, "CMA National Physician Health Survey: a national snapshot," (October 2018), TAB 32 BOD VOL 1.
[39] Kane L., "Death by 1000 Cuts": Medscape National Physician Burnout & Suicide Report. 2021, TAB 33 BOD VOL 1.
[40] OMA Burnout, *supra,* TAB 30 BOD VOL 1; see also Gajjar J, Pullen N, Li Y, et al, "Impact of the COVID-19 pandemic upon self-reported physician burnout in Ontario, Canada: evidence from a repeated cross-sectional survey" BMJ Open 2022;12:e060138. doi: 10.1136/bmjopen-2021-060138 ["Gajjar"], TAB 34 BOD VOL 1. (published results from white paper above)
[41] *Ibid.*

system sustainability, practice environment for practicing physicians, the culture of medicine, and compensation and financial pressures.[42]

65. Moral injury and moral distress are different but related concepts but related to burnout and can themselves be contributors to burnout. Moral distress occurs when physicians struggle to do or are constrained from doing what they believe is morally correct. Instances of moral distress build up over time to become moral injury, "a profound sense that you've betrayed your own ethical code (or were unable to follow it because of external factors)". It is associated in health care workers with feelings of guilt, shame, and anger and can lead to depression, PTSD, and suicide or suicidal ideation. Some of the factors identified as contributing highly to burnout– e.g., health system sustainability and increasing administrative work that imposes additional workload and takes away from patient care also can contribute to moral distress and development of moral injury, which, in turn, can cause burnout.[43]

VII. Physician Human Resources Crisis

66. In addition to the challenges outlined above, Ontario is also now in the midst of a growing physician human resources crisis, affecting many specialties and geographic areas. Some regions such as the North and rural and remote areas endure chronic undersupply issues that have never been effectively addressed. Various specialties are increasingly having difficulty recruiting and retaining new physicians. As well, the Ontario population is increasing, aging, and experiencing a higher volume and complexity of health issues. Indeed, the COVID pandemic exposed the many cracks in an unintegrated, fragmented system which does not effectively support its health care workforce or optimize patient access to high-quality health care close to home. The OMA refers the Board to Part Seven of the brief for more information about the scope and breadth of this problem.

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[42] OMA Burnout, *supra.*

[43] Martha Hostetter and Sarah Klein, "Responding to Burnout and Moral Injury Among Clinicians," *Commonwealth Fund* (August 17, 2023), TAB 35 BOD VOL 1; See also Rosen, A., Cahill, J.M. & Dugdale, L.S. "Moral Injury in Health Care: Identification and Repair in the COVID-19 Era," J GEN INTERN MED 37, 3739–3743 (2022). https://doi.org/10.1007/s11606-022-07761-5, TAB 36 BOD VOL 1.

67. In conclusion, physicians and the health care system are under tremendous strain and facing many challenges. The OMA submits that this broader context must be taken into account in assessing its Year 1 compensation proposal and when determining the fair and appropriate compensation increase.

PART THREE - THE BINDING ARBITRATION FRAMEWORK

68. The present arbitration is taking place pursuant to the Binding Arbitration Framework Agreement ("BAF"),[44] which sets out the dispute resolution process to be used by the parties in the event they cannot reach a negotiated settlement with respect to the Physician Services Agreement ("PSA"). It was signed by the parties on May 16, 2017 and subsequently ratified by the membership and is intended to operate in perpetuity subject, of course, to mutually agreeable amendments. A description of the key elements of the BAF is set out below.

69. Each PSA under the BAF is for a period of 4 years, commencing April 1, unless the parties agree otherwise (Section 1). Bargaining for the renewal of the PSA is to begin six months before it expires (Section 2). The parties are required to bargain in good faith and to disclose all relevant data to each to enable informed bargaining to take place (Sections 4, 5). While bargaining is continuing and until an agreement is reached or, failing agreement, the arbitration hearing has been concluded and an award issues, the government cannot unilaterally alter the terms of a PSA or unilaterally alter any terms covering any matter falling within the scope of arbitration (s. 3, 6). The parties can bargain and mediate on any items but, as noted below, only certain matters can be submitted to final and binding arbitration.

70. If the parties are unable to reach an agreement after 60 days of bargaining, either party can request mediation. The mediator is either appointed by the parties or, failing agreement, by the Chief Justice of Ontario. Unless otherwise agreed, the mediator will also be the Chair of the Board of Arbitration. William Kaplan has been the mediator and chair of the Arbitration Board for the 2017-21, the 2021-24 and the current 2024-28 PSA. At the initiative of either party after 60 days of mediation, or if the mediator declares an impasse, the dispute will be referred to binding interest arbitration (see sections 7, 8, 12, 13, 15).

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[44] Binding Arbitration Framework ["BAF"], TAB 37 BOD VOL 1, which is Appendix A to the OMA and MOH, Representation Rights and Joint Negotiations and Dispute Resolution Agreement, TAB 38 BOD VOL 1.

71. *Binding interest arbitration:* After negotiation and mediation, if the parties cannot agree on a PSA, an Arbitration Board will determine the terms of the PSA. Its decision will be final and binding on government and the OMA. The Arbitration Board will be comprised of an independent chair, and a nominee from each party. The individual selected as the mediator will also be the chair of the Arbitration Board (unless the parties agree to someone else to be the chair of the Arbitration Board). (See sections 8, 9, 17, 30, 31 and 32). Each party appoints their nominee to the Arbitration Board. In the current arbitration, the government nominee is Dr. Kevin Smith; Michael Wright, a lawyer in Toronto, is the OMA nominee.

72. The Arbitration Board will have full power to decide any issue in dispute, on such terms as it determines to be appropriate. It is not limited to choosing either the OMA's position or the government's position (s. 18). The Arbitration Board is given the authority to determine all matters related to the conduct of the hearing. There are very limited powers of review of the final decision of the Arbitration Board (s. 19). The Arbitration Board can, on its own motion or if requested by either side, appoint an expert advisor(s) to assist in considering the issues; however, both parties are entitled to question the expert and to introduce expert evidence on their own (section 29).

73. The Arbitration Board is also expected, but not required, to issue its decision within 60 days after the last day of hearing (s. 20). The parties will share the costs of the mediator/chair of the Arbitration Board (s. 33).

74. The BAF defines the matters which are within the scope of arbitration in a number of sections and in Schedule A which include: payments for fee-for-service ("FFS"), alternate payment plans ("APPs") and alternate funding plans ("AFPs"), primary health care (including physician compensation in Family Health Teams ("FHTs") such as the blended salary model and FHT sessional fees), hospital on-call coverage ("HOCC") flow-through top up for public health physicians, and physicians in divested psychiatric hospitals and assertive community treatment teams, and payments to physicians for services under the Ontario Telemedicine Network program (s. 21(a)).

75. The Arbitration Board can determine the conditions to be met in order to be paid on a fee-for-service for an insured service as well as accountabilities and activities under a non-fee—for service arrangement and the payments for such.

76. The Arbitration Board can address what is or is not to be included in the Physician Services Budget (PSB) and how the PSB is to be calculated. In the first arbitration award for the 2017-2021, the Board rejected the government's proposal to put a hard cap under the PSB on physician billings.

77. In addition, the Board of Arbitration has jurisdiction to consider accountabilities and activities under a non-fee-for-service arrangement and the payments for such as well as payments under the Canadian Medical Protective Association ("CMPA") or any other malpractice insurance program.

78. There are matters which are specifically excluded from the scope of arbitration under section 23 which include Workplace Safety and Insurance Board ("WSIB") payments, the addition or deletion of fee codes (provided there is no "nil" billing code for anything delisted), government funding for non-physician services and pensions.

79. The agreement provides a list of factors for the Arbitration Board to consider, and also provides that the Arbitration Board is to consider any other factors it considers relevant. In other words, the Board is not bound by any factor and can determine the weight to be given to the respective factors (s. 25). The listed factors are:

(a) The achievement of a high quality, patient-centred sustainable publicly funded health care system;

(b) The principle that compensation for physicians should be fair (in the context of such comparators and other factors that the Arbitration Board considers relevant) and reasonable;

(c) Such comparators as the Arbitration Board considers to be relevant, including but not limited to, physician compensation;

(d) The economic situation in Ontario;

(e) Economic indicators that the Arbitration Board considers relevant, including, but not limited to, the cost of physician practice;

(f) Evidence-based relativity and appropriateness considerations; and

(g) Data sources agreed to by the parties to be reliable, or otherwise the most reliable data available.

80. The agreement sets out the process for the Arbitration Board to determine changes to physician compensation and the PSB. The Arbitration Board will first determine changes to physician compensation, and any issues relating to the PSB. The Arbitration Board may then, if it considers appropriate, also determine that an amount should be set aside for distribution/allocation based on evidence-based relativity, evidence-based appropriateness, evidence-based value considerations, and any of the other listed criteria li. If the Arbitration Board orders this, the OMA and government will meet to negotiate on the distribution/allocation, and if they cannot agree, the distribution/allocation will be decided by the Arbitration Board (s. 26).

81. As noted above, the parties have agreed to the sequence in which the various issues will be determined by the Arbitration Board in this round. The subject-matter of the present initial phase of arbitration is to determine the Year 1 overall price/compensation increase for the 2024-2028 PSA.

82. Separate and apart from the role of the mediator and the Board of Arbitration during negotiations and as outlined above, the BAF provides for a Referee, who will be agreed to by the parties, or appointed by the Chief Justice if the parties cannot agree. The Referee will be an arbitrator with the power to make a final and binding decision whenever there is a dispute between the OMA and government over: the rules and procedures under the Framework Appendix itself (s. 36) the terms of any PSA (s. 39), and the terms of any agreements reached during PSA negotiations (s. 39).

PART FOUR - CRITERIA FOR THIS INTEREST ARBITRATION

83. In the 2019 Kaplan arbitration award, Arbitrator Kaplan discussed the criteria found in s. 25 of the BAF. While noting that no single factor should be "accorded primacy," he explained that "at the centre of [the board's] mission in resolving the matters in dispute is to ensure a high-quality patient-centred sustainable publicly funded health care system with fair and reasonable compensation for Ontario's physicians."[45]

84. Arbitrator Kaplan also recognized, in considering the government's proposal for a "hard cap" on the Physician Services Budget, that the government cannot "requir[e] Ontario doctors to subsidize public services."[46] The OMA submits, however, that, since 2012 (and only partially rectified in the 2017-21 PSA), limits on physician price increases has resulted in physicians subsidizing the delivery of medical services by assuming an increasing clinical and administrative workload (amplified by the impact of the pandemic) with limited improved financial return for their efforts. This has only been compounded by the constraints imposed during negotiations for the 2021-24 PSA by Bill 124 which effectively limited physician price increases, holding them below inflation and the increases received by others. While the OMA's members are dedicated at all times to delivering high-quality patient-centred care, they must be fairly and reasonable compensated for doing so.

85. As Arbitrator Kaplan observed in the 2019 award, the "other criteria are directly relevant to the achievement of [a high-quality patient-centred health care system]." Of particular significance to the current arbitration is "economic indicators including…the cost of physician practice"[47] which is of particular relevance in the face of the historic impact of inflation on physicians during the term of the 2021-4 PSA.

86. Arbitrators also have particular regard to issues of "recruitment and retention" in making their awards, a factor which is critical in this arbitration when considering the

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[45] *Ministry of Health and Long-Term Care and Ontario Medical Association,* (February 18, 2019, unpublished) ["2019 Kaplan Arbitration Award"] at p. 4, TAB 1 of OMA's Book of Authorities ["BOA"].
[46] *Ibid.* at p. 8.
[47] *Ibid.* at p. 4

overall objective identified by Mr. Kaplan's Award of achieving a high-quality patient-centred health care system. Current and predicted recruitment and retention issues, the shortage of physicians and its impact on the delivery of services throughout the health care system must be addressed by this Arbitration Board through appropriate and needed price increases. While such increases will not automatically resolve the recruitment and retention issue, compensation is unquestionably a driver in attracting employees.[48] The same can undoubtedly be said with respect to the physicians who are the subject of this arbitration.

87. With respect to the other criteria listed in the BAF, Arbitrator Kaplan further noted that "replication and identification of appropriate comparators" are "key interest arbitration criteria."[49]

88. Indeed, as has been recognized by countless arbitrators, the overarching goal of interest arbitration is to replicate the agreement that the parties would have achieved in free collective bargaining, had they been able to do so, with or without the resort to strikes or lockouts.[50] This approach was summarized by Professor Weiler in *Grandview Private Hospital* as follows:

> Interest-dispute arbitration…is intended to provide a procedural substitute for strike within a process of free collective bargaining. An arbitrator must look at labour market realities, i.e. the relative economic and bargaining positions of the parties, in attempting to simulate the agreement which could have been reached by the parties under the sanction of a strike or lockout. The best evidence of this hypothetical agreement is the pattern of development in other comparable hospitals in the community, especially those collective agreements voluntarily concluded.[51]

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[48] *The Crown in Right of Ontario v The Ontario Secondary School Teachers' Federation and The Elementary Teachers' Federation of Ontario*, 2024 CanLII 8967 (ON LA) ["ETFO and OSSTF"], TAB 2 BOA.
[49] 2019 Kaplan Arbitration Award, *supra,* at p. 8, TAB 1 BOA.
[50] Re Board of School Trustees, District No. 1 (Fernie) and Fernie District Teachers' Association (1982), 8 LAC (3d) 157 at 159 (CLB) Dorsey ["Re Board of School Trustees"], TAB 3 BOA.
[51] Cited in *Re Beacon Hill Lodges of Canada and Hospital Employees Union*, (1985) 19 L.A.C. (3d) 288, TAB 4 BOA.

89. The former Chief Justice of Ontario, Warren Winkler, has explained the replication principle as follows in *Re University of Toronto (Governing Council) and University of Toronto Faculty Association*:

> Determining an award in replication of an agreement that might have been reached in the context of the "economic power struggle" and the "exigencies of the market-place"...requires consideration of a number of dynamic elements including the specific employer-employee relationship, the specific "industry" or "industry segment" and the general economic conditions and climate in which both exist.…
>
> ...The replication principle requires the panel to fashion an adjudicative replication of the bargain that the parties would have struck had free collective bargaining continued. The positions of the parties are relevant to frame the issues and to provide the bargaining matrix. However, it must be remembered that it is the parties' refusal to yield from their respective positions that necessitates third party intervention. Accordingly, the panel must resort to objective criteria, in preference to the subjective self-imposed limitations of the parties, in formulating an award. In other words, to adjudicately replicate a likely "bargained" result, the panel must have regard to the market forces and economic realities that would have ultimately driven the parties to a bargain.[52]

90. Arbitrators have noted that interest arbitration is not a scientific exercise, particularly in the public sector:

> In the public sector, finding a yardstick in the "real world" to tailor an appropriate replicated or simulated award is an unscientific task. It must not be too rigid and static or it will stifle future bargaining by making the outcome of arbitration too easily predictable. At the same time, it must not be purely speculative or have no basis in rational matching of like circumstances. The award should pay close attention to the concerns of the parties and the information they produce, *but it will necessarily be an impressionistic, instinctive assessment of the parties' circumstances, the times and the over-all economic health of the community.* Much of that cannot be articulated.[53]

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[52] University of Toronto and University of Toronto Faculty Association (Salary and Benefits Grievance) (2006), 148 L.A.C. (4th) 193 at paragraphs 12-17, TAB 5 BOA.
[53] *Re Board of School Trustees, supra*, (emphasis added), TAB 3 BOA.

91. At the same time, “freely bargained outcomes are the touchstone” when trying “to replicate free collective bargaining, and to ensure that the parties end up no better and no worse than if their right to strike and lockout had not been curtailed.” [54]

92. In the face of high inflation, arbitrators have also recently reiterated in their awards that replication means addressing and responding to increases in the cost of living. As Arbitrator Kaplan explained in the OPG award:

> Even if inflation has slowly begun to abate, the increases in the cost of living are now fixed (absent a sustained period of de-inflation, which no economist is predicting). Inflationary increases are both dramatic and entrenched... *Addressing inflation in settlements and awards has become normative*. [55]

93. Similarly, applying the replication principle, Arbitrator Kaplan in the *CUPE and OHA* award, refused to follow to earlier arbitration awards that had not addressed inflation noting that “[f]ollowing either of these reopeners would not be replication since the overall settlement trend is completely contrary to either of these outcomes.” [56]

94. As stated by Arbitrator Goodfellow in *Bridgepoint Health*, “comparability puts the flesh on the bones of replication, providing the surest guide to what the parties would likely have done, in all the circumstances, had the collective agreement been fully and freely bargained.” [57] The use of relevant comparators also “assists in evaluating the competitive and economic conditions that are at play when determining what the parties may have negotiated on their own.” [58]

95. In the OMA’s submission, in the context in which the present arbitration arises, the arbitral criteria of economic circumstance, replication, comparability and recruitment and retention should be given particular consideration and support the OMA’s proposals. As

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[54] *Participating Hospitals v CUPE/OCHU & SEIU (Bill 124 Reopener),* 2023 CanLII 50888 (ON LA) [“CUPE/OCHU and SEIU”], TAB 6 BOA.
[55] *OPG v The Society*, 2023 CanLII 37956 (ON LA), TAB 7 BOA.
[56] *CUPE/OCHU and SEIU, supra*, TAB 6 BOA.
[57] *Bridgepoint Hospital v Canadian Union of Public Employees, Local 79*, 2011 CanLII 76737 (ON LA), TAB 8 BOA.
[58] *F.J. Davey Home v Canadian Union of Public Employees, Local 4685-00,* 2021 CanLII 10816 (ON LA), TAB 9 BOA.

set out below, the OMA reviews the application of these criteria as they bear on normative increases.

96. It is important to add, as well, a note about the specific impact of the decision of the Superior Court of Justice and the Ontario Court of Appeal that Bill 124 was unconstitutional. There was no stay sought from the decision of Justice Koehnen and, accordingly, even while the government was pursuing its appeal of that decision, numerous unions took advantage of the “reopener” provisions they had negotiated into their Bill 124 agreements to argue for and receive significant compensation increases beyond those limited to them under Bill 124. These arguments took place against the backdrop of acknowledge historic inflationary increases during the same period.

97. Although not covered by the provisions of Bill 124, the OMA recognized, during the last round of bargaining, that it was very unlikely to receive greater increases than the imposed 1% if it had proceeded to arbitration before the constitutionality of Bill 124 had been determined. The OMA did not have a formal reopener provision in the 2021-2024 PSA and, accordingly, is now seeking increases for Year 1 of the 2024 PSA which will remedy and provide catchup for the amounts that should and could have been negotiated but for the very real practical restraints imposed by the existence of Bill 124 at the time their last PSA was concluded. Ontario’s doctors must now receive the price increases that would have been and should have been negotiated and awarded during the 2021-24 PSA, and bearing in mind what we now know about inflation over that time period. They cannot be deprived of the appropriate, just and necessary remedy for unconstitutional legislation that was made available and received by many others in the broader public sector and by all of their colleagues in the health care sector.

PART FIVE - HISTORICAL OVERVIEW OF BARGAINING TO PRESENT

98. An important part of the context for the present arbitration and to enabling the Board of Arbitration to properly assess and appreciate the OMA's proposal is the history and background of bargaining between the parties since 2012.

99. Until 2012, with the exception of a brief period during the legislated "Social Contract" of the 1990s, the parties were largely able to successfully negotiate physician price increases and adjustments through a series of agreements providing regular increases to the OHIP fee schedule, along with other appropriate and necessary financial measures.

100. In sharp contrast, the period between 2012-2017 was marked by significant fee cuts and unilateral government actions including unilaterally imposed caps on the Physician Services Budget (overall expenditures on physician services), and unilateral across-the-board as well as targeted reductions to physician compensation. These measures reduced the average billings per physician, while at the same time average physician costs of practice were increasing (although not as significantly as the rate of inflation over the past three years).

A. 1981-2012 NEGOTIATIONS

101. In the 1980s, the government and OMA were able to successfully negotiate physician compensation, including regular increases to the OHIP fee schedule.

102. For example, the OMA and Ontario government concluded agreements that provided for increases to the OHIP Schedule of 3% effective April 1, 1985 and 3% effective April 1, 1986. On June 26, 1987, the OMA and Ontario government reached a further agreement that provided a 5.05% increase to the OHIP Schedule effective April 1,1987. It also provided for a $6 million lump sum payment, in order to fully fund the cost associated with an increase in Canadian Medical Protective Association ("CMPA") premiums for medical malpractice insurance that had taken effect in 1987.

103. In 1991, the OMA and Ontario government entered into a new Framework Agreement, which included a binding arbitration process, as well as principles to guide the Ontario government and OMA's ongoing collaboration in overseeing physician services in Ontario. The parties then concluded the 1991 Interim Agreement, which provided for a global increase of 3.5% (plus an additional conditional increase to account for utilization) to the OHIP Schedule effective for fiscal year 1991-1992. A Memorandum of Agreement on Retroactivity Payments was also concluded, which gave Ontario physicians retroactive compensation payments in respect of the 1989-1990 period.

104. On December 17, 1992, the OMA and the Ontario government agreed to increase the OHIP Schedule by 1% effective October 1, 1992 for the 1992-93 fiscal year.

105. This period of regularly negotiated increases to the OHIP fee schedule was briefly interrupted in the 1993-1996 period, when the provincial government of the day introduced the "Social Contract," a series of sweeping austerity measures aimed at cutting government spending.

106. As a result, consistent with the Social Contract legislation, the government entered into an agreement with physicians in 1993 which included expenditure reductions in fee-for-service billings and alternate payment arrangements under OHIP. In addition, the 1993 Interim Agreement imposed a "hard cap" on the total amount available for fee-for-service payments under OHIP for the period from 1993 to 1996 and implemented a process through which billings that exceeded the hard cap would be "clawed back."

107. The formal or legal austerity of the Social Contract however ended in 1996, but normative increases in payment for physician services continued to be significantly constrained. After several months of negotiations, the OMA and government reached an Interim Agreement on December 15, 1996, and a final three-year agreement respecting the provision of physicians' services on May 14, 1997. These agreements provided for annual 1.5% increases to the OHIP Schedule in fiscal years 1996-1997, 1997-1998, and 1998-1999, confirmed that the Social Contract claw-backs on physician billings would

expire as scheduled, and guaranteed that no further claw backs would be introduced for the term of the agreement.

108. On April 26, 2000, the OMA and the government entered into a new PSA for the term April 1, 2000 until March 31, 2004[59]. That agreement provided for annual increases to the OHIP schedule of 1.95% in the first year, and 2% in each of the three remaining years of the agreement, with a 2003 reopener based on "prevailing economic conditions". It also included a commitment to move forward with family medicine reform, and several patient care enhancement initiatives, including after-hours premium codes, payments for hospital on call coverage, and other initiatives in such areas as low volume obstetrics, home care, complex care of the elderly and mental health sessional payments.

109. As the result, the social contract period of cutbacks, restraint and austerity was followed by modest increases to fees under the OHIP Schedule for the period April 1, 1996 to March 31, 2004, resulting in fee increases from 1993 to 2004 being materially lower than the rate of inflation.[60]

110. As in the present context relating to the 2012 to 2024 period, the resulting deterioration in physician compensation over the 1996-2004 period, above and beyond the specific impact of the Social Contract, presented a significant challenge to the MOH and OMA negotiators as they prepared for the 2004 negotiations: to negotiate an agreement that would address this deterioration, respond to the increasing difficulty of Ontarians accessing primary health care, and promote the recruitment and retention of physicians by introducing appropriate care models with appropriate adjustments in compensation.[61]

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[59] OMA and Ministry Physician Services Agreement 2000, TAB 39 BOD VOL 1.
[60] Data Source: Statistics Canada, CANSIM 326-0020 Consumer Price Index (CPI) (Ontario) (2002 = 100).
[61] OMA, Media Release "74% of Ontario Doctors Support New Contract with Government" (March 30, 2005) [OMA March 30, 2005 Release], TAB 40 BOD VOL 1, News Release "McGuinty government and Ontario's doctors achieve ground-breaking deal" (March 30, 2005) [MOH March 30, 2005 Release] TAB 41 BOD VOL 1; OMA, Media Release "79% of Ontario's Doctors Vote in support of New Agreement with Province" (October 18, 2008) [OMA October 18, 2008 Release], TAB 42 BOD VOL 1; MOH, News Release "New Agreement with Doctors Improves Access To Care" (October 18, 2008) [MOH October 18, 2008 Release], TAB 43 BOD VOL 1.

111. The parties concluded a reopener to the 2000 PSA in April 2003, providing for new funding for academic health science centres to better meet patient care needs, enhancements to hospital on-call coverage, and enhancement to various fee codes and new fee codes. It also provided for the establishment of the primary care Family Health Group ("FHG") model, and enhancements and improvements to the Family Health Network ("FHN") primary care models, both of which were aimed at responding to a growing crisis in family medicine.[62]

112. It is worth noting that, like today, the crisis in medicine was not limited to family practice but family medicine was where the crisis was most acute. By the early 2000s, it was widely recognized that family medicine in the province faced severe challenges which were summarized, in a 2001 report, by the Ontario College of Family Physicians as follows:[63]

> Family Medicine is in crisis. There are too few Family Physicians available to deliver comprehensive continuing care for each person in this province…
>
> Canadian Institute for Health Information (CIHI) confirms that the number of Family Physicians in the province actually declined by 4% during the last five years. In the same space of time, the general population has increased, and the population most in need of care (i.e. the aged) has increased significantly...
>
> It is not surprising the Family Physicians all over the province are showing signs of burn out. They are expected to look after more complex cases, both in the acute care setting, as well as in long-term care facilities and the community. The uncertainty around Primary Care Reform initiatives and the impending growth of the population as the baby-boomers age and require more health services merely adds to their burden.…
>
> Surveys of Family Physicians reflect their growing frustration with the workload... We are already seeing the effects of burn out in the style of practice in many communities in Ontario where Family Physicians are giving up providing the comprehensive care they have been trained to deliver. Less than 25% of Family Physicians continue to provide obstetrical services….

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[62] OMA and Ministry Physician Services Agreement 2003, TAB 44 BOD VOL 1

[63] Ontario College of Family Physicians, "Where Have all the Family Doctors Gone? A Discussion Document (February 2001) at pp. 11-14, TAB 45 BOD VOL 2.

> The morale of Family Physicians is very low and surveys reveal that many now plan early retirement or at least a further reduction in the range of services they are willing to provide. It is important to realize that retiring doctors in the last two years usually had no physician available to take over their practice and consequently, their retirement left an additional group of patients to join the increasing pool of "orphan" patients…
>
> New medical school graduates are well aware of the current problems in Family Medicine. Less than 30% of last year's graduating class choose Family Medicine as their choice of specialty (the lowest number since the 1960's). Many of the new graduates are refusing to set up practice, choosing to do locums or move to the United States instead.

113. As discussed in greater detail below, over twenty years later, we are now once again facing a renewed crisis in family medicine.

114. Recognizing that the severe challenges to the provision of medical service went beyond family medicine, the Ontario government mandated an independent Expert Panel on Health Professional Human Resources to study all physician resources in the province. In its 2001 report, the Panel concluded that "Ontario has physician shortages throughout the system," "that the shortages are particularly acute in rural and remote areas," and that the province would "have a shortage of 1,367 physicians in 2010 – if it does nothing to increase the supply of physicians in the province."[64]

115. Along with doctor shortages, Ontario was also facing problems with increasing wait times. As the George Report found, as of 2000, "patients referred to a medical specialist were waiting between 5.5 and almost 12 weeks for a first consultation; patients referred to a surgical specialist were waiting between three weeks and 14 weeks for a first consultation."[65]

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[64] Expert Panel on Health Professionals Human Resources, Shaping Ontario's Physician Workforce: Building Ontario's Capacity to Plan, Educate, Recruit and Retain Physicians to Meet Health Needs (January 2001) (Dr. Peter George, Chair) at pages 6 and 61 ["George Report"], TAB 46 BOD VOL 2.
[65] *Ibid*. at page 19.

116. Compounding this crisis was the fact that doctors had not seen any meaningful increase to their compensation in the previous decade as overall mean payments to physicians in Ontario "remained fairly flat between 1992-93 and 2003-04."[66]

117. With this stark reality and resulting challenge as the background, negotiations for the successor 2004-2008 PSA were long and hard, with the OMA members rejecting a tentative agreement reached between the parties in the late fall of 2004. Following this rejection, the parties entered into a second tentative agreement, which also included new rules on incorporation to allow for non-voting shareholders who are family members of the physician voting shareholders. On the basis of these and other changes, this second agreement was ratified in March of 2005.[67]

118. At the outset of the agreement, both parties explicitly acknowledged that improved funding, both in amount and application, was essential to help achieve change. The agreement then recorded that:

> 1.3 For this purpose, the MOH has made a wide range of investments in this Agreement intending to increase access to physician services, improve and extend comprehensive primary care, provide integrated in-hospital and after hospital care, increase long-term care services and improve academic medicine in our valuable academic health science centres. In addition, these investments allow us to address important issues of physician human resources, physician compensation and practice workloads and styles, all of which have significant impact on the effectiveness and efficiency of the health care system. These issues will be dealt with elsewhere in this Agreement.

119. The agreement then identified a number of agreed "investments in health care" including the following:[68]

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[66] Institute for Clinical Evaluative Sciences, "Payments to Physicians from the Ministry of Health and Long-Term Care Sources 1992/3 to 2009/10" (February 2012) at Executive Summary, TAB 47 BOD VOL 2.

[67] 2004-2008 Physician Services Agreement between the OMA and MOH ["2004 PSA"], TAB 48 BOD VOL 2; see also OMA March 30, 2005, Release, TAB 40 BOD VOL 1 and MOH March 30, 2005 Release, TAB 41 BOD VOL 1.

[68] *Ibid.*

- A general fee increase of 2.5% for general practitioners/family physicians and 2% for specialists, retroactive to April 1, 2004, in addition to various targeted fee codes with targeted fee increases provided for under the agreement;

- New incentives and improvements for comprehensive family medicine models, including the creation of Family Health Teams;

- Improved funding and new investments for physicians in academic health science centres;

- Improved fee incentives for specialists providing in-hospital care, long-term and community care;

- Premiums to encourage physicians to practice in rural and remote communities;

- New on-call fee incentives in long-term care homes, home care and palliative care and expanding hospital on-call coverage and in-hospital care fees for specialists;

- Elimination of previous individual physician billing thresholds in order to shorten wait times for tests and treatment; and

- Enhanced incorporation benefits to permit income-splitting with family members.

120. In their public statements, both parties recognized that the settlement was necessary in order to address "the critical doctor shortage"[69] and "make Ontario an attractive place to practice medicine."[70]

121. The 2004-2008 agreement provided for a re-assessment in its final year. As a result, in June 2007, the OMA and Ontario government entered into a re-assessment agreement that, among other things, provided for targeted increases to various services under the OHIP Schedule in joint recognition of the fact that "retention of physicians in Ontario is dependent upon the Parties keeping the schedule up-to-date and reflecting

[69] OMA March 30, 2005, Release, supra, TAB 40 BOD VOL 1.
[70] MOH March 30, 2005, Release, supra, TAB 41 BOD VOL 1.

new procedures, best practices and latest evidence". The 2007 agreement also provided for enhanced primary care incentive payments in such areas as unattached patients, obstetrical coverage, and after-hours premiums.[71]

122. The negotiations for the subsequent 2008-2012 PSA were largely driven by the jointly recognized need to continue to improve access to family medicine physicians for Ontarians and to address the doctor shortage. At that time, the province had suffered a net loss of physicians for two consecutive years, resulting in a shortage of 2,500 physicians and leaving more than 850,000 patients with no family physician.[72]

123. Against this backdrop, the parties entered into the 2008-2012 PSA in September 2008, with a term from April 1, 2008 to March 31, 2012 (the "2008 Agreement"), which was formally ratified by the OMA membership in October 2008. The 2008 PSA provided for a 3% lump sum payment on OHIP billings for the year beginning October 1, 2008, a 5% increase to OHIP fees effective October 1, 2009, a further 3% increase October 1, 2010, and a final 4.25% effective September 1, 2011.[73]

124. With respect to these global increases, the agreement also provided that, in the second, third and fourth years of the agreement, one-half of the increase in each year was to be allocated on an equal percentage basis to each OHIP Specialty, while the other half of the increase each year would be allocated to OHIP Specialties by the Physician Services Payment Committee ("PSPC"), based upon a relativity methodology agreed to by the parties. While the parties used the pre-existing OMA RVIC relativity methodology to distribute the 2009 increase, the government and OMA agreed to use the revised OMA CANDI relativity methodology for the third and fourth years.

125. The agreement also included the following:

- A shared objective of attaching a minimum of 500,000 unattached patients to family physicians, through investments in new fees and

[71] 2007 Memorandum of Agreement between OMA and MOH, TAB 49 BOD VOL 2.
[72] OMA October 18, 2008 Release, OMA TAB 43 BOD VOL 1.
[73] 2008 Memorandum of Agreement between OMA and MOHLTC, TAB 50 BOD VOL 2.

enhancements, as well as providing for in and out of office service bonuses, and incentives for chronic disease management for diabetes, GP focused practice and inter-professional shared care;

- Enhanced funding for most responsible physicians admitting unscheduled patients;
- $340 million in new program funding and incentives;
- Additional funding for hospital on-call programs;
- Enhanced emergency department funding to improve timely access;
- Funding for the Northern Ontario School of Medicine; and
- New funding for AFP and APP recruitment.

126. The Ontario government communications emphasized that the 2008 PSA would result "in family health care becoming available to more Ontarians," reduce "congestion in hospital waiting rooms" and "help 500,000 Ontarians without a family physician find one,[74] objectives that need to be met, again, today.

127. The increases to compensation and other items negotiated under both the 2004 and 2008 PSAs were driven by both parties' recognition of the need to respond to real health care system challenges, including the need to "increase access to physician services, improve and extend comprehensive family medicine, provide integrated in-hospital and after hospital care, increase long-term care services and improve academic medicine in our valuable academic health science centres."[75] Those agreements reflected and recognized the failure to adequately and appropriately maintain fair and competitive physician compensation over the previous decade, and the challenges, if not

[74] MOH October 18, 2008 Release, TAB 43 BOD VOL 1.
[75] 2004 PSA, *supra* at sec. 1.3, TAB 48 BOD VOL 1.

the crisis, in recruiting and retaining physicians in this province and providing health care to Ontarians, particularly in respect of family medicine. History has now come full circle.

B. 2012 UNILATERAL ACTIONS AND SUBSEQUENT NEGOTIATIONS

128. In stark contrast to this earlier period, negotiations between 2012 and 2017 were marked by unilateral action including targeted fee cuts on the part of the government with a profoundly negative and harmful impact on fair and reasonable physician compensation. Moreover, in the absence of a fair and independent arbitration process, the Ministry was able to unilaterally erase a significant portion of physician compensation increases previously agreed to in prior Agreements.

129. In early 2012, the negotiations towards a new PSA were suspended when, on May 7, 2012, the government announced unilateral changes to the OHIP Fee Schedule, including a sweeping reduction in fees for 37 physician services, with the government's goal being to strip $339 million from physician compensation in 2012-2013.[76] These cuts included a reduction in fees for colonoscopy, gastroscopy, electrocardiograms, cataract surgeries and for interpreting the results of diagnostic radiology, as well as reduced fees for anesthesia services. In addition, there was a proposed 50% reduction in the fee for self-referral for diagnostic services.

130. In response to the fee cut, the OMA launched a constitutional challenge alleging that the right of Ontario's physicians to freedom of association under the Canadian *Charter of Rights and Freedoms* had been violated by the government's unilateral actions.

131. With the metaphorical gun of the cuts pointed at its head, the OMA resumed negotiations with the Ministry in September 2012, and, on November 3, 2012, reached a tentative agreement on a new Physician Services Agreement for the period October 1, 2012 to March 31, 2014 ("PSA 2012").[77] This agreement included changes to 6 of the 37 unilateral fee cuts, including a reversal of the self-referral fee reduction, a smaller

[76] Health Services Branch, Ministry of Health and Long-Term Care, INFOBulletin 4561, Amendments to the Schedule of Benefits for Physician Services - Effective April 1, 2012" (May 7, 2012) [INFOBulletin 4561], TAB 51 BOD VOL 2.
[77] 2012 Physician Services Agreement Between OMA and MOH, TAB 52 BOD VOL 2.

reduction in the anesthesia flat fee, an adjustment to the optical coherence tomography fee (although it remained lower than it was prior to the unilateral action), and a return to the after-hours premium and intensive and coronary care premiums in place prior to April 1, 2012.

132. In the absence of a fair and independent binding arbitration process at that time, the unilateral cuts to the 31 other fees remained and represented a combined 5% fee cut largely a result of the previously announced OHIP fee cuts from May 2012. In dollar and percentage terms, the combined effect of the 2012 unilateral actions and the PSA was a reduction of $521.6 million or 5.1% as shown in the chart below:

Item	Description	Impact ($ million)	% Impact
2012 UA	Total Fee Cuts	-$335.7	-3.3%
2012 PSA	Partial Reversal	$75.5	0.8%
2012 PSA	Net New savings	-$261.4	-2.6%
Total End Rate	Net 2012 UA and PSA	-$521.6	-5.1%

133. In addition, PSA 2012 also included a payment discount of 0.5% on all payments to physicians. In total, the 2012 PSA included various concessions extracted from the profession which provided government with hundreds of millions of dollars in savings.[78]

134. The negative impact of the 2012 unilateral action and concessions in the 2012 PSA on Ontario physician compensation was immediate. Moreover, the average gross clinical payments per Ontario physician decreased by 1.9% over the course of the agreement (2012-2014) while the average gross clinical payment to physicians in the rest of country increased during the same time period.[79]

135. As part of the 2012 negotiations, the parties also entered into the Ontario Medical Association Representation Rights and Joint Negotiation and Dispute Resolution

[78] OMA, News Release, “New agreement between Ontario’s doctors and government protects patient care” (9 December 2012), TAB 53 BOD VOL 2. See also: OMA, Executive Summary, “Tentative 2012 Physician Services Agreement Executive Summary”, TAB 54 BOD VOL 2.
[79] CIHI Table A.1.4, TAB 55 BOD VOL 2.

Agreement,[80] pursuant to which the government recognized the OMA as the exclusive bargaining agent of physicians, and also agreed to consult and negotiate in good faith over physician compensation. However, while the 2012 Representation Rights Agreement provided for resort to a facilitator, and then conciliation in the event the facilitator was unsuccessful, the government refused to agree to a binding arbitration process, and retained the right to take unilateral action once facilitation and conciliation had been completed.

C. FAILED NEGOTIATIONS IN 2014

136. Despite the 5% overall cut to various fees, and the 0.5% payment reduction, the government sought even further and deeper concessions from the OMA when the parties began negotiations for a 2014 PSA. Specifically, in August 2014, the government presented its position on the basic financial elements of PSA 2014 to the OMA negotiating team which included:

- Regardless of patient demand or need, growth in the total amount of funding for physician services could only increase by 1% per year during the term of PSA 2014 over and above a baseline figure of $11.146 billion (which was less than actual expenditures in the prior year);

- If spending did, in fact, grow by more than 1% per year (which the Ministry expected), physician compensation would be reduced; accordingly, and

- A “reconciliation” mechanism was introduced to hold back or claw back physician payments in the event that any of the savings/compensation reduction measures established in the agreement were not achieved.

137. In the Ministry’s view, strongly contested by the OMA, PSA 2014 needed to account for a “savings shortfall” of $204 million that resulted from a failure to attain the

[80] OMA and MOH, Ontario Medical Association Representation Rights and Joint Negotiation and Dispute Resolution Agreement, 2012, *supra,* TAB 38 BOD VOL 1.

projected savings associated with compensation reduction initiatives established in PSA 2012.

138. The Ministry's spending on reimbursement to physicians for medical malpractice insurance through the Canadian Medical Protective Association ("CMPA") was to be capped at 2% annual growth from 2013-2014 on, despite the agreement on CMPA in the 2012 PSA.

139. From the OMA's perspective, it did not appear that the Ministry was open for negotiations in any real or meaningful way. As well the government indicated that it was not prepared to negotiate the amount of total funding that it would provide for physician services during the term of the PSA, having already imposed caps on spending by virtue of the of the 1% limit on growth in annual spending.

140. Faced with the government's intransigence, the OMA commenced the non-binding Facilitation - Conciliation process referenced above. The OMA and Ministry participated in this process between September and December 2014, resulting in a confidential non-binding Facilitation Report from Dr. David Naylor and a non-binding Conciliator Report in December 2014 from former Chief Justice Warren Winkler,[81] covering the three-year period from 2014 to 2017.

141. Following the Winkler Report, on December 16, 2014, the government delivered to the OMA an offer for PSA 2014 that would cover the 2014-2015, 2015-2016, and 2016-2017 fiscal years (the "December 16 Offer"). The December 16 Offer had the following main elements:

- Total annual spending on the Physician Services Budget (the "PSB") would be capped at a growth rate of 1.25% per year (the "Capped PSB");

[81] Conciliator's Report, Warren Winkler, Q.C, December 11, 2014, TAB 56 BOD VOL 2.

- Over the course of the first two years of the agreement (2014-2015 and 2015-2016), the parties would implement specific measures to achieve $580 million in compensation reductions in the PSB;

- If total actual spending on physician services exceeded the capped PSB for 2014-2015 and 2015-2016, the excess expenditure would be recovered from physicians in 2016-2017; and,

- A similar recovery mechanism based on 1.25% spending growth in the third year of the agreement (2016-2017), would be introduced but the Ministry would also make a $117 million lump sum payment available to physicians.

142. On January 9, 2015, the government issued a revised "final offer," which was identical to the December 16 Offer in all respects except for a modification on how the $580 million in required compensation reductions would be achieved.[82] Specifically, instead of the additional 1% "across-the-board" reduction to all fees for physician services set out in the OHIP Schedule found in the December 16 Offer, the Final Offer provided for fee reductions that would have applied differentially across the various physician specialties covered by the OHIP Schedule but allowed those physician specialties to identify specific reductions to reduce or eliminate those fee reductions in the future (the "Reverse CANDI Methodology"). As a result of this allocation, the across-the-board reduction contemplated by the December 16 offer was reduced to 0.5% (to achieve a total of $73.5 million in savings).

143. However, on January 12, 2015, the government revised its position again and presented an "Implementation Plan" that provided for $321 million in reductions through an across-the-board reduction of 3.15% (the previous 0.5% reduction continued in effect by government from PSA 2012, and an additional 2.65% reduction) applicable to fee-for-

[82] January 9, 2015 MOH Final Offer to the OMA, TAB 57 BOD VOL 2. The $580 million was reduced to $530 million from physicians, with the remaining $50 million to be found in system savings.

service billings and payments made under Primary Care and Alternative Payment Plan contracts.[83]

144. On January 14, 2015, the government further amended the Final Offer to provide that physicians would be responsible for $530 million in savings from the PSB in 2014/2015 and 2015/2016 and the Ministry would increase the 2016-2017 lump sum payment from $117 million to $168 million.[84] It also confirmed that it would not implement "reconciliation" to recover any amounts from physicians in respect of fiscal years 2014-2015 and 2015-2016 until the end of 2015-2016.

145. The revised Final Offer would have imposed unlimited financial responsibility for growth in the PSB on Ontario's physicians, at the same time as it ignored the fact that actual growth in the PSB would be far greater than the proposed 1.25% a year, having regard to the utilization factors (such as population growth, aging, various demographic factors, and net new supply of doctors) for which government now agrees that, at a minimum, it is responsible, as set out in section 21(d)(iii) of the BAF.

146. The OMA Board unanimously rejected the final offer on January 14, 2015.

D. GOVERNMENT UNILATERAL ACTION IN 2015

147. In response, on January 29, 2015, the government took unilateral action against Ontario physicians, enacting *Ontario Regulation 15/15*,[85] which effectively imposed the

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[83] Ministry of Health and Long-Term Care's Implementation Plan, January 7, 2015 (Revised January 12, 2015), TAB 58 BOD VOL 2.
[84] January 14 Amendment to January 9, 2015 Ministry Offer, TAB 59 BOD VOL 2.
[85] *O. Reg. 15/15:* GENERAL, filed January 29, 2015 under *Health Insurance Act, R.S.O. 1990, c. H.6.* TAB 60 BOD VOL 2. See also Implementation Plan Update for the OMA, January 29, 2015, TAB 61 BOD VOL 2; Health Services Branch, INFOBulletin 2105, "Implementation of the 2.65% Payment Discount", February 12, 2015, TAB 62 BOD VOL 2; Ministry of Health and Long-Term Care, INFOBulletin 4646, "Amendments to the Schedule of Benefits for Physicians Services and Payment Discount of 2.65%," February 12, 2015, OMA TAB 63 BOD VOL 2; Primary Health Care Branch, Ministry of Health and Long-Term Care, INFOBulletin 11125, "Changes to Primary Health Care Physician Payments" (February 12, 2015), TAB 64 BOD VOL 2; Negotiations Branch, INFOBulletin 4647, "Continuing Medical Education Reimbursement Program for Course/Product Expenses Discontinued," February 12, 2015, TAB 65 BOD VOL 2. For a discussion of the 2015 cuts and their impact on health care services see: Ontario Hospital Association and Ontario Medical Association, "OHA/OMA Analysis of the Government's Unilateral Action: Ten-Point Plan for Saving and Improving Service," (2015) ["OHA/OMA Ten-Point Plan"], TAB 66 BOD

Final Offer, and included a further 2.65% reduction to "fee-for-service" payments to physicians effective February 1, 2015, along with amendments to the OHIP Schedule that reduced the fees payable under OHIP for certain physician services effective April 1, 2015.

148. Together with the unilateral discounts to fee-for-service payments, the MOH also announced that a 2.65% discount would also be applied to specific physician payment programs effective June 1, 2015. These programs included: Complex Continuing Care (CCC); Hospital Paediatric Stabilization; Physician On-Call ("POC"") in Long-Term Care; Psychiatric Stipend and Rural Medicine Investment Program ("RMIP").[86] As well, the clinical funding for Alternative Payment Plans ("APPs"), Alternative Funding Plans ("AFPs") and Alternative Funding Agreements ("AFAs") was also subject to the 2.65% across-the-board discount, which also applied to all payments for clinical services under various primary care agreements, including physician payments by salary, sessional, per diem and capitation-based mechanisms, effective June 1, 2015.[87]

149. As noted, these payment discounts were in addition to the 0.5% across-the-board discount that had been in place since 2013.

150. The MOH also announced that it was amending the OHIP Schedule to reduce the fees payable under OHIP for certain physician services effective April 1, 2015 including a 5% reduction in the A888 fee code--an assessment code rendered on weekends and holidays for seeing unscheduled patients for urgent medical problems-- from $35.40 to $33.70. In addition, the fee code for the chronic disease premium E078 for services provided by Internal Medicine, Nephrology, Gastroenterology and Cardiology was completely eliminated.[88]

VOL 2. See also Ontario Hospital Association, "OHA Analysis of Ministry of Health and Long-Term Care's Additional Reductions to Funding for Physician Services," TAB 67 BOD VOL 2.

[86] Health Services Branch, Ministry of Health and Long-Term Care, INFOBulletin 4648, "Payment Discount – Non-Fee-For-Service Physician Payment Programs," (February 17, 2015) [INFOBulletin 4648], TAB 68 BOD VOL 2.

[87] MOH INFOBulletin 11125, TAB 64 BOD VOL 2.

[88] Implementation Plan, Update for the OMA, at slide 2, TAB 61 BOD VOL 2.

151. Along with the measures described above, on February 12, 2015, the MOH also announced a number of further measures specifically directed at family physician compensation.

152. These measures included the elimination of:[89]

- Certain patient enrollment fee codes;
- Per patient rostering fees;
- Certain Health Care Connect Program Fees and certain payments in respect of complex vulnerable patients; and
- Interim acuity modifier payments. These additional payments had been provided in recognition of the higher care needs of some patients on a family physicians' roster, which were not addressed through the age/sex adjusted capitation rates.

153. All of these measures were effective June 1, 2015.

154. Other unilateral measures specifically directed at family physicians included the reduction in the number of physicians permitted to enter into Family Health Networks ("FHN") and Family Health Organization ("FHO") models. Under the 2012 PSA, there had been "managed entry" of 40 new physicians into the FHN and FHO models each month (20 in a priority stream and 20 in a stream based on application date). However, effective June 1, 2015, registration in these models was limited to only 20 physicians a month, and only in areas of high need as determined unilaterally by the government.[90] Similarly, effective June 1, participation in the Income Stabilization Program was limited to eligible physicians being able to join a FHN or FHO only in areas of high need.[91] This program

[89] InfoBulletin 11125, *supra*, TAB 64 BOD VOL 2.
[90] *Ibid.* TAB 64 BOD VOL 2.
[91] *Ibid.*

was intended to help physicians joining either FHN or FHO groups by providing stable monthly payments in the first year of practice while they developed their patient "roster".

155. The government also unilaterally cut the HOCC One Time Payment, which was a stipend that the parties had agreed to implement for above minimum call shift requirements for HOCC groups of less than 5 physicians,[92] and froze funding for the HOCC program at current levels, meaning that no new HOCC groups/group members (including those waiting approval) would be approved.[93]

156. Beginning on September 18, 2015, the government took further unilateral action when it enacted *Ontario Regulations 283/15, 302/15,* and *303/15* ("October 2015 changes").[94] These Regulations, effective October 1, 2015, included the following:

- An additional 1.3% reduction to fee-for-service payments effective October 1, 2015 (bringing the total discount to 4.45%);
- A new 1% reduction, retroactive to April 1, 2015, to the professional component of FFS claims for professional fees paid over $1,000,000. This calculation was to be done after all other payment discounts were made, although this particular action has not been implemented;
- Elimination/reduction of professional fee codes for diagnostic imaging; In total the fee changes affecting medical imaging equated to a 20% reduction in all diagnostic ultrasound and nuclear medicine services in Ontario;[95]

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[92] Brittany Harrison and Merry Guo, "2015 Ontario Health Cut Backs: Overview and Specific Impact on Primary Care" University of Ottawa Journal of Medicine, Vol. 5 No. 1 (2015) 1-5, TAB 69 BOD VOL 2.
[93] *Ibid.*
[94] O. Reg. 283/15, TAB 70 BOD VOL 2; Health Services Branch, INFOBulletin 4657, "REVISED – Payment Reduction on Fee-for-Service Professional Fee Payments of $1 Million or more, Payment Discount of 1.3%, and Amendments to the Schedule of Benefits for Physician Services," September 14, 2015, TAB 71 BOD VOL 2; Fee Changes and Fee Code Deletions – Effective October 1, 2015, TAB 72 BOD VOL 2.
[95] Canadian Association of Radiologists, "Statement – Ontario Fee Cuts will Result in Limited Access to Timely, Quality Patient Care" (October 1, 2015), TAB 73 BOD VOL 2.

- Elimination/reduction of professional fee codes for point of care laboratory services;

- New requirements for eligibility for the Diabetes Management Incentive (3 assessments to same patient in 12-month period);

- Elimination of pre-operative consultation payments for low risk elective surgery, including cataract surgery, colonoscopy, cystoscopy, carpal tunnel surgery, and arthroscopic surgery;

- Elimination of certain fee codes for applying cardiac Doppler, and changes and reductions to other related cardiac Doppler fee codes; and

- Reduction of fees for intravitreal injections (from $105 to $90).

157. In dollar terms, the impact of 2015 unilateral action can be summarized as follows:

Item	Description	Impact ($ million)	% Impact
2015 January UA	ATB (2.65% on all clinical payments excluding HOCC) and targeted cuts	-$451.4	-4.5%
2015 Oct UA	ATB (1.3% on FFS only) and targeted cuts	-$214.7	-2.1%
Total End Rate	Net 201% UA	-$666.1	-6.5%

E. *CHARTER* CHALLENGE, 2016 TENTATIVE AGREEMENT AND ITS REJECTION BY OMA MEMBERS

158. At some point after the 2015 unilateral changes were imposed, the OMA and government recommenced discussions, focused on the OMA's position that physicians were entitled to a binding arbitration dispute resolution mechanism. As well, the OMA

brought a second *Charter* challenge on October 29, 2015, asserting the constitutional right to a process of binding arbitration and challenging the unilateral cuts.[96]

159. On July 11, 2016, the parties announced that they had reached a tentative agreement, although the OMA's right to continue its *Charter* challenge seeking binding arbitration was not affected. However, this tentative agreement was overwhelmingly rejected by 63% of Ontario physicians.[97]

F. BINDING ARBITRATION FRAMEWORK, KAPLAN ARBITRATION AND 2017-2021 PSA

160. Subsequently, the parties returned to negotiations and in June 2018, they agreed to the Binding Arbitration Framework, described above. The BAF established an independent consensually selected board of arbitration that was given the mandate to determine outstanding issues respecting the content of the 2017-2021 and future PSAs.[98]

161. Consistent with the PSA, this 2017-21 arbitration was to be conducted in phases. In Phase One of the process, the OMA advanced proposals related to redress for the 2014-2017 period, general fee increases, Academic Health Sciences Centres ("AHSC"), the Northern Ontario School of Medicine ("NOSM"), additional increases and a process for reviewing technical fees, and redress resulting from changes to federal legislation governing physician incorporation. For its part, the MOH advanced proposals for a hard cap on the PSB, and for cuts and fee reductions to certain radiology, ophthalmology and cardiology fees. As well, both parties advanced proposals respecting the delivery of family medicine, particularly through FHOs.

162. The parties proceeded to arbitration before a board of arbitration chaired by William Kaplan in 2018, ending in early 2019. The Board's decision was released on

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[96] Ontario Medical Association v Ontario (Minister of Health and Long-Term Care) and Lieutenant Governor in Council of Ontario, Notice of Application, Court File CV-15539424, October 29, 2015, TAB 74 BOD VOL 2.
[97] Rob Ferguson, "Ontario doctors reject contract deal with province," *The Toronto Star* (August 15, 2015) TAB 75 BOD VOL 2.
[98] BAF, *supra,* TAB 37 BOD VOL 1

February 18, 2019.[99] In its reasons, the Board rejected the Ministry's hard cap proposal, finding that it would be "intrinsic[ally] unfair", and that "the Ministry is responsible for the PSB including growth."[100] With respect to redress, the board partially accepted the case for redress, finding that doctors "uniquely were the only group to have their compensation cut, and these cuts continue" and that it was "not wage restraint normally given expression in a freeze" but "confiscatory."[101] Accordingly, the Board ordered, as a partial redress, that the 2.65% for non-fee for service and 3.95% for fee-for service 2015 payment discounts be removed as of April 1, 2019. However, all of the other targeted cuts remained in place.

163. Turning to the fee increases, having reversed and rejected the Ministry proposal for a hard cap, and having rejected the Ministry's proposal to impose further targeted fee reductions, and having directed that the across-the-board fee cuts be reversed, the Board went on to award the following modest across the board increases:

- 0.75% compensation adjustment in 2017-18;
- 1.25% compensation adjustment in 2018-19;
- 1.0% compensation adjustment in 2019-20 with a portion of this adjustment to be applied to remove the 0.5% payment discount under the 2012 PSA; and
- 1.0% compensation adjustment in 2020-21.

164. No other OMA monetary proposals were awarded. With respect to family medicine, the Board awarded the establishment of a "Multi-Stakeholder Primary Care Working Group" to examine into and make recommendations on a number of issues including access and quality issues, walk-in clinics, complexity modifiers and other issues as identified by either party." For AHSCs and NOSM, the Board only awarded a $7.5 million increase to the AHSC AFP innovation fund effective April 1, 2019, with a further $2.5

[99] 2019 Kaplan Arbitration Award, *supra,* TAB 1 BOA.
[100] *Ibid.* at p. 8.
[101] *Ibid.*at p. 16.

million effective April 2, 2020, and directed the parties to continue discussions over rightsizing and repair. For the OMA's technical fee proposal, the board directed the parties to further study and examine the issue.

165. The Award also established the Appropriateness Working Group to discuss and establish evidence informed amendments to payments by eliminating or restricting inappropriate or overused physician services or physician payments.

G. BILL 124, THE 2021-2024 PSA, AND THE CURRENT ROUND

166. Prior to the commencement of bargaining for the 2021-2024 PSA, the government passed the now unconstitutional *Protecting a Sustainable Public Sector for Future Generations Act, 2019*[102] ("Bill 124"). Bill 124 imposed a three-year compensation restraint or "moderation period" for employees in the broader public sector, including the health sector, during which there was a hard cap of 1% on any increases to salary rates during each 12-month period in the three-year moderation period and a separate overall 1% annual hard cap on any incremental increases to existing or new compensation entitlements (which includes any increases to salary rates).

167. While Bill 124 did not strictly apply to physicians and the PSA, it did apply to virtually all other health sector workers. Bargaining for the 2021-2024 PSA was, thus, conducted under the constraints and cloud of Bill 124, which significantly impacted and restricted the negotiations. The OMA recognized and accepted that, at a time when, as a result of Bill 124, and in the midst of the pandemic, nurses and other health care workers would not receive increases of more than 1%, there was no prospect of physicians being awarded increases in excess of 1%.

168. The parties entered in the 2021-2024 PSA on February 10, 2022. Shortly after the negotiations began, the parties were required to address the "new reality" of providing physician services during a pandemic, which led, amongst other things, to discussion of the establishment of codes for the delivery of health care "virtually". Other COVID-related

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[102] *Protecting a Sustainable Public Sector for Future Generations Act, 2019*, SO 2019, c 12, s 10 [*Bill 124*], online: https://www.ontario.ca/laws/statute/s19012 .

issues dominated the first several months of negotiations as the parties sought to adjust to providing and compensating physicians in a pandemic environment.

169. The OMA recognized the reality of Bill 124 and its impact on any financial agreement it could reach or hope to have arbitrated, and that, particularly where the rest of the health sector had their wages capped at 1% a year, a similar result would inevitably be imposed at arbitration. As a result, the parties agreed to payments of 1% increase in each of the first two years of the agreement, 2021-22 and 2022-23. The Year 3 increase was to have been determined based on the difference between what physician expenditures were expected to be in 2023-24 had there not been a pandemic and what actual expenditures turn out to be. Pursuant to the terms of the February 2024 Implementation and Procedural Agreement, the parties have agreed that the overall compensation increase is 2.8% for Year 3 (without prejudice to the position of either party respecting the need for and appropriateness of catch-up over the prior period).

170. In addition, the 2021-2024 PSA included the following changes:

- A permanent framework for virtual care by telephone and video, when appropriate. Both patients and physicians had found virtual care to be effective, efficient and convenient during the pandemic;
- Modest easing of “managed entry” restrictions thereby enabling more family doctors to join Family Health Organizations;
- Additional changes in family medicine and, in particular, to Family Health Organizations such as complexity, mandatory group size, and acuity modifiers;
- Improved parental leave benefits, which will allow early and mid-career physicians to spend more time with their families and help address both work-life balance and physician burnout;
- The repair of specific underfunded APPs;

- Implementation of a process to develop and implement additional APPs including APPs for Laboratory Physicians, Genetics and Infectious Diseases;
- Continuation of funding for CMPA until the renewal of the next PSA; and
- A modified Appropriateness Working Group process.

171. However, after the PSA was agreed to and ratified (in March 2022), numerous unions successfully argued before the Ontario Superior Court that Bill 124 infringed on and denied the associational rights and freedoms guaranteed by s 2(d) of the *Charter* and was not justified under s. 1. On November 29, 2022, the Ontario Superior Court of Justice struck down Bill 124 in *Ontario English Catholic Teachers Assoc. v. His Majesty*.[103] The Superior Court concluded:

> The Act prevents collective bargaining for wage increases of more than 1%. This restriction interferes with collective bargaining not only in the sense that it limits the scope of bargaining over wage increases, but also interferes with collective bargaining in a number of other ways. For example, it prevents unions from trading off salary demands against non-monetary benefits, prevents the collective bargaining process from addressing staff shortages, interferes with the usefulness of the right to strike, interferes with the independence of interest arbitration, and interferes with the power balance between employer and employees I find that these detrimental effects amount to substantial interference with collective bargaining both collectively and individually.
>
> In the context of this case, the Act is not a reasonable limit on a right that can be demonstrably justified in a free and democratic society under s. 1 of the *Charter.*

172. The government then appealed this decision. On February 12, 2024, the Ontario Court of Appeal issued its decision. A majority of the Court of Appeal upheld the trial judge's conclusion that Bill 124 violated the right to collective bargaining in s. 2(d) of the

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[103] *Ontario English Catholic Teachers Assoc. v. His Majesty*, 2022 ONSC 6658 (CanLII) ["*OECTA"*] at para. 9, TAB 10 BOA.

Charter[104] and that it could not be saved under s. 1 of the *Charter.* The government subsequently announced that it would not appeal this decision.

173. Notably, virtually all health sector workers, who were subject to Bill 124, had "reopener" clauses in their collective agreements, which allowed them to renegotiate compensation for the restraint period. As a result of these reopener settlements and awards, and as detailed in the comparator discussion below regarding OMA's Year 1 compensation proposal, they were able to renegotiate/arbitrate additional across the board and targeted increases over the three-year restraint period, including significant wage grid adjustments to address the growing recruitment and retention challenge across the health care sector.

174. Together with the history of unilateral action between 2012 and 2017, and the very modest increases provided under the 2017-21 PSA, the repeal of the unconstitutional Bill 124 forms the overwhelming background and context for the OMA's proposal for catch-up. As will be detailed below, the combined general increases under the 2021-24 PSA are only 4.8%. This is significantly lower the rate of inflation over the three-year period 2021-24, and significantly lower than the increases received by other health sector workers under their reopeners.

175. The OMA acknowledges that there is no reopener in the PSA for the 2021-24 period and, accordingly, this board of arbitration has no jurisdiction or authority to award price increases for the 2021-24 period to address rising inflation and the increasing costs of practice, or to reflect the increases received by other groups under reopener provisions to which Bill 124 had applied. As a result, physicians will not be able to receive the same level of retroactive increases as did other health care groups in respect of the 2021-24 period nor to receive protection against inflation over that same period. However, as set out more fully below, in all of the circumstances, it is fair, appropriate and justifiable for the Year 1 increase for physicians to include an amount that reflects the increases received by other groups over the 2021-24 period and the bases for those increases as

[104] *Ontario English Catholic Teachers Association v. Ontario (Attorney General),* 2024 ONCA 101 (CanLII), TAB 11 BOA.

one component of the price increase effective April 1, 2024, i.e. in Year 1 of the 2024-2028 PSA.

176. Moreover, while the Kaplan Award for the 2017-21 PSA provided some limited redress for some of the historic losses experienced by physician over the 2012-2017 period (reversing only the across the board fee cuts), it did not provide anything near full redress; rather, it focussed on a categorical rejection of the Ministry's attempt to impose a hard cap on physician service expenditures, a total dismissal of its attempt to impose further fee cuts on certain specialties. In that context, it is not surprising that the 2017-21 PSA Award, provided for very modest price increases, out of step with those negotiated or awarded by other comparator groups. All of this must be taken into account in respect of the OMA's overall request for a 10.2% Year 1 catch-up component.

177. In the OMA's submission, this overall bargaining history is the most relevant background factor that this Board must consider in determining the appropriateness of the OMA's Year 1 price increase catch-up proposal. As this history reveals, as a result of unilateral cuts and lower than normative increase, physician price increases have failed entirely to keep pace with inflation since 2012, since 2017 and since 2021, and have failed to keep pace with the increases provided to the most relevant comparators in the Ontario health sector, including in respect of the Bill 124 period.

PART SIX - ONTARIO'S ECONOMIC AND FISCAL POSITION

178. Pursuant to section 25(d) and (e) of the *2017 Binding Arbitration Framework,* the "economic situation in Ontario" and "[e]conomic indicators that the arbitration board considers relevant" are two of the criteria to be considered by the Board in the present arbitration.

179. The OMA submits that its proposals find support in the stable economic and fiscal performance of Ontario currently, and the very strong economic performance in the prior 2021-24 period. After significant growth in 2021 and 2022, Ontario's economy continues to demonstrate "resiliency"[105] and is on solid footing. Indeed, according to government projections, by 2026-27, it will be in a surplus position.[106]

180. At the same time, recent and continuing persistent high inflation and the resulting rising costs of practice has significantly eroded the price for physician services and physician compensation. Indeed, physicians not only experience inflation in the price for their services not keeping pace with increases to the cost of living; their practice costs have also been subject to the inflationary spiral, further eroding the real price of their rate of compensation.

181. Indeed, these more recent inflationary pressure have exacerbated the previous reality that, since 2008 Ontario's health spending per capita has consistently ranked at or near the lowest in Canada, evidence of a persistent underfunding of health services, including physician services, by the Ontario government.[107] The time has now come to address this situation and to ensure that physician services are properly and adequately funded.

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[105] Ontario, Building a Better Ontario: 2024 Ontario Budget (March 26, 2024) at p 3 ("2024 Budget"), TAB 76 BOD VOL 3.
[106] Ontario, Fall Economic Outlook, 2023, at p. 3, TAB 77 BOD VOL 3.
[107] Financial Accountability Office of Ontario, *2022-23 Interprovincial Budget Comparison,* (April 10, 2024) at p. 1 ("*Interprovincial Budget Comparison"*), TAB 78 BOD VOL 3.

A. ONTARIO'S ECONOMY IS STABLE AND CONTINUING TO GROW

I. GDP

182. In the post-pandemic period, Ontario's economy has rebounded rapidly with real GDP seeing exceptional gains in 2021 and 2022 of 5.4% and 3.9% respectively.[108] As the recent 2024 Ontario Budget has confirmed, Ontario's economy continues to be resilient, with "better than expected performance" demonstrated by a 1.2% increase in real GDP in 2023.[109]

183. For the term of the 2024-2028 PSA, according to projections in the 2024 Budget, real GDP will grow at a modest 0.3% in 2024, before increasing to 1.9% in 2025, and 2.2% in 2026-2027.[110] These numbers are consistent with those from the Financial Accountability Office ("FAO") which has projected that economic growth will improve to an average of 2.0% over the 2025 to 2028 period as interest rates fall.[111]

184. When compared to earlier periods, after the economic uncertainty of the pandemic, Ontario's economic growth is projected to return to a steady pre-pandemic pace:

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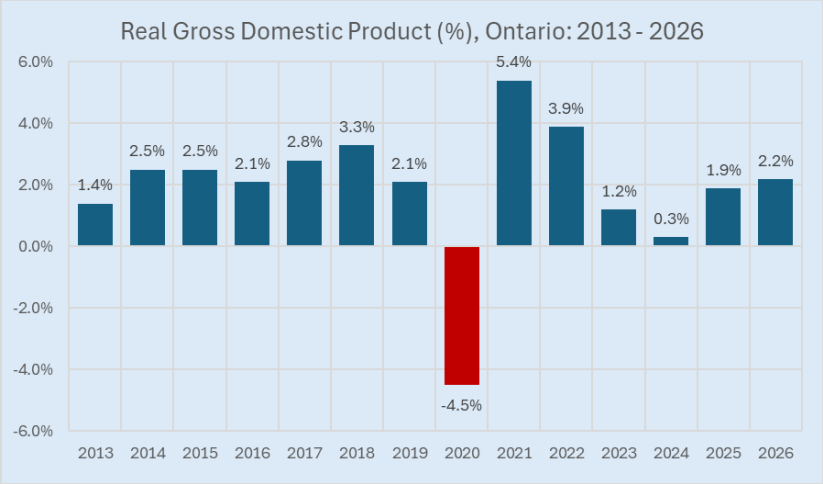
[108] Financial Accountability Office of Ontario, Spring 2023 Economic and Budget Outlook ("FAO Spring 2023 Outlook") at pp 1-2, TAB 79 BOD VOL 3; see also Financial Accountability Office of Ontario, Winter 2024 Economic and Budget Outlook ("FAO Winter 2024 Outlook"), TAB 80 BOD VOL 4.
[109] 2024 Budget, *supra* at p 115, 120 TAB 76 BOD VOL 3.
[110] 2024 Budget, *supra* at p 115, TAB 76 BOD VOL 3.
[111] FAO Winter 2024 Outlook, *supra* at p. 5, TAB 80 BOD VOL 3.



Source: Statistics Canada (2013 - 2023, 36-10-0222-01); 2024 Ontario Budget 2024 - 2026).

185. The Ministry of Finance further estimates that Ontario's nominal GDP expanded by 4.1% in 2023, noticeably higher than the government's estimate of 2.8% in the *2023 Budget* projection.[112] Nominal GDP growth is projected to be 2.7% in 2024. Over the 2025 to 2028 period, nominal GDP growth is expected to average 4.1% annually, supported by stronger employment growth, sales gains and lower interest rates.[113]

186. Data from Statistics Canada published on March 28, 2024, after the 2024 Budget was released, confirms that Canada's economy is continuing to perform strongly. Statistics Canada reports that "[r]eal gross domestic product (GDP) grew 0.6% in January [2024]" and notes that overall "there was broad-based growth with 18 of 20 sectors increasing in January."[114] In addition, the "manufacturing sector fully recouped December's decline with a 0.9% increase in January," with the "motor vehicle manufacturing industry increas[ing] 4.9% in January, as production resumed at some auto assembly plants following retooling-induced partial shutdowns in the previous months."[115]

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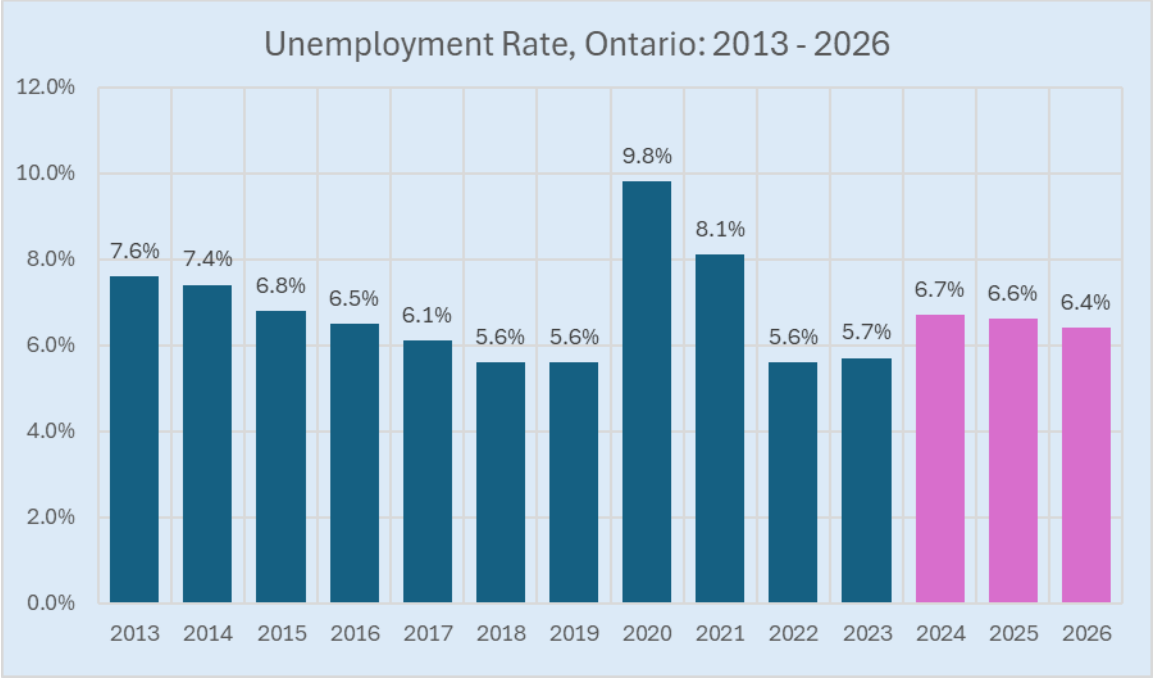
[112] 2024 Budget, *supra* at p 116, TAB 76 BOD VOL 3.
[113] *Ibid.*
[114] Statistics Canada: "Real GDP in January 2024 much stronger than anticipated," (March 28, 2024), TAB 81 BOD VOL 3.
[115] *Ibid.*

187. As this data confirms, 2024 has opened with very robust GDP growth and the Canadian economy continues to outperform expectations, with Ontario's manufacturing industry, in particular, showing strength. With such a "strong start to the year, real GDP is tracking for an annualized gain of 3.5% in the first quarter, well above the Bank of Canada's expectations for 0.5%."[116]

II. Employment

188. The post-pandemic period in Ontario has also been marked by strong job growth, resulting in a very tight labour market. In 2022, the annual unemployment rate in Ontario dropped to 5.6%, the same as the pre-pandemic rate observed in 2019.[117] While it is projected to increase slightly in 2024-2026, it will remain relatively low at 6.4-6.7%.



Source: Statistics Canada (2013 - 2023, 14-1--0023-01); 2024 Ontario Budget 2024 - 2026).

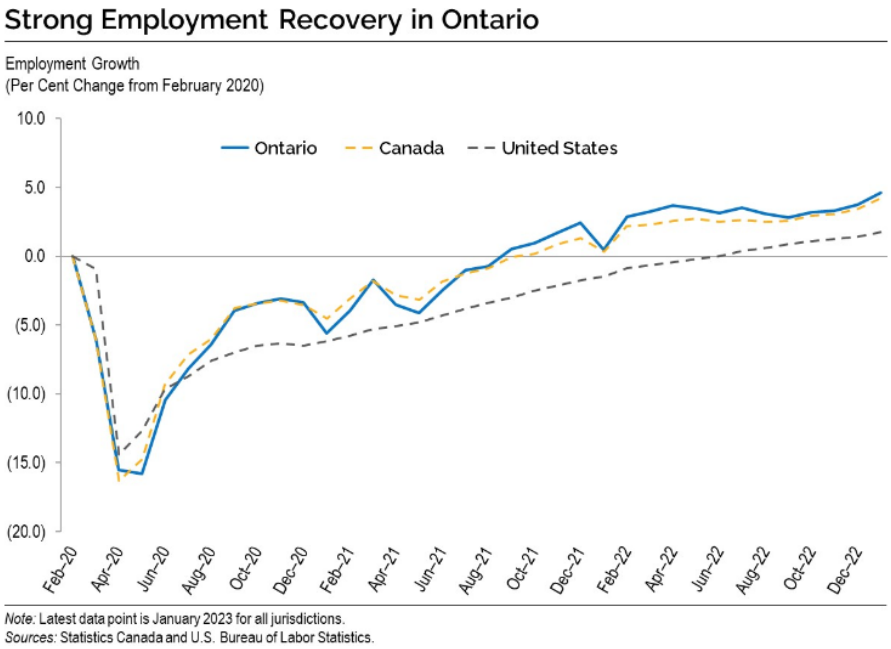
[116] Craig Lord, "Robust' GDP growth to start 2024 puts Bank of Canada in tough spot: economists" Global News, March 28, 2024, TAB 82 BOD VOL 3.
[117] Financial Accountability Office of Ontario, *Ontario's Labour Market in 2022*, March 21, 2023 at p. 1, TAB 83 BOD VOL 3.

189. Notably, the historically low unemployment rate of 5.6% in 2022, which matched the pre-pandemic rates in 2018 and 2019, were the lowest since the late 1980s. As noted, the combination of low unemployment and high levels of employment has resulted in a very tight labour market at present.[118] The projected unemployment rates going forward, while slightly higher than these historic lows, will allow for a slight easing of the labour market while still remaining low.

190. According to the FAO, in 2023, employment increased by 183,200 jobs (2.4%).[119] Similarly, the Ontario government reported that "[d]espite ongoing economic headwinds, Ontario continued to experience above average employment growth in 2023, adding 183,200 net new jobs, a 2.4% increase. This followed record gains of 5.2% in 2021 and 4.6% in 2022. Job creation over the 3-year period since 2021 is the highest on record."[120] In its *2023-2024 Third Quarter Report,* the Government also noted that "[m]ost of the net employment gains in 2023 were in full-time positions (93% of the net total) and in the private sector (92% of the net total).[121]

191. As well, as reflected in the following chart from the March 2023 Budget, from a comparative perspective, Ontario's employment growth since the pandemic and during the relevant time period, also compares favourably to that of the rest of Canada and the United States:[122]

[118] Ontario, Building a Strong Ontario: 2023 Ontario Budget (March 23, 2023) at p 109 ("2023 Budget"), TAB 84 BOD VOL 3.
[119] Ibid.
[120] 2024 Budget*, supra* at p 118, TAB 76 BOD VOL 3.
[121] Ontario, 2023-34 Third Quarter Finances (February 12, 2024) ("23-24 Third Quarter Report"), TAB 85 BOD VOL 4.
[122] 2023 Budget*, supra* at p. 109, TAB 84 BOD VOL 3.



192. In addition, as explained by the FAO, labour income growth in particular has remained "resilient, with hourly wages extending strong grains in most industries throughout 2023."[123]

193. Thus, according to economic indicators, Ontario's economy is in a stable position with increasing growth expected in the coming years.

B. ONTARIO'S FISCAL POSITION

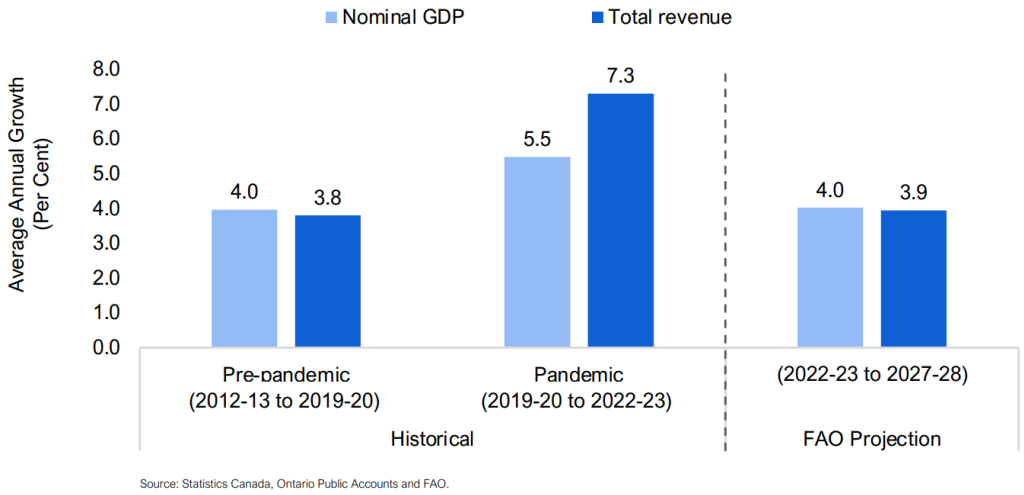
I. Revenue Growth

194. From a fiscal perspective, Ontario is also on stable footing. According to the 2024 Budget, revenues in 2023–24 are projected to be $204.3 billion, which is $1.6 billion higher than projected in Ontario's *2023-2024 Third Quarter Report.* Revenues in 2024-25 are projected to be 205.7 billion.[124] This is mainly due to "higher taxation revenue, other non-tax revenue and net income from Government Business Enterprises, after factoring in a decline in Government of Canada transfers."[125] This increase in revenue is projected

[123] FAO Winter 2024 Outlook, *supra* at p. 6, TAB 80 BOD VOL 3.
[124] 2024 Budget, *supra* at p 146, TAB 76 BOD VOL 3.
[125] *Ibid.*

to continue, rising to $226.6 billion in 2026-2027, amounting to an average annual growth rate in revenue of 3.5%.[126]

195. Looking forward, the FAO is projecting revenue growth will average 3.9% per year from 2022-23 to 2027-28. Notably, this is comparable to average annual growth in the pre-pandemic period.[127]



196. On the revenue front, however, it is also important to note that Ontario has the capacity for even higher revenue. According to the FAO, and as reflected in the following chart, in 2022, Ontario received $12,643 in total revenue per capita, the lowest among the provinces and $4,034 (24.2%) below the average for the rest of Canada ($16,676). In 2022, Ontario collected $9,687 in tax revenue per capita, $92 (0.9%) below the Canadian average of $9,779. Measured against economic activity, Ontario's tax revenue (14.0% of GDP) was also below the average of the other provinces (14.5% of GDP). Since 2008, Ontario has consistently collected the lowest or second lowest revenue per capita among the provinces. Thus, Ontario has options and capacity to fund necessary health services, including physician services.[128]

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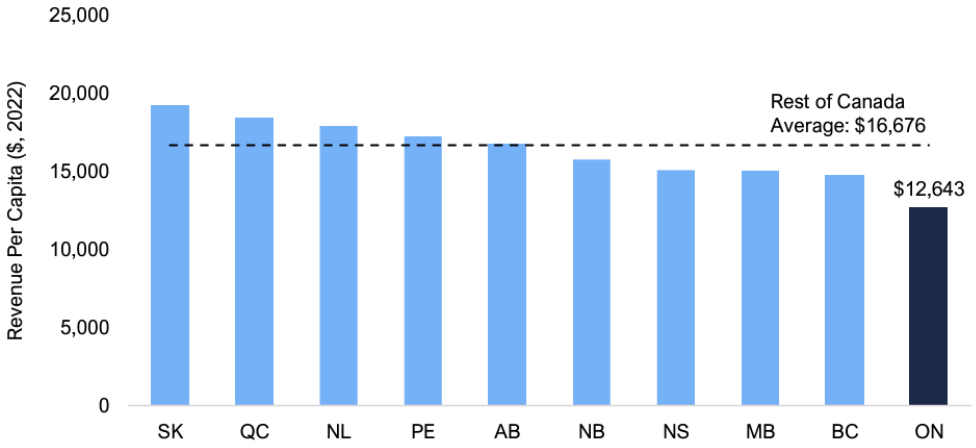
[126] *Ibid* at p 152.
[127] FAO Winter 2024 Outlook, *supra* at p. 10, TAB 80 BOD VOL 3.
[128] Financial Accountability Office of Ontario, *2022-23 Interprovincial Budget Comparison: Comparing Ontario's Revenues, Spending, Budget Balance and Net Debt with Other Provinces* (April 10, 2024) ("FAO Interprovincial Comparison"), *supra* at TAB 78 BOD VOL 3.

Ontario's revenue per capita was the lowest in Canada in 2022



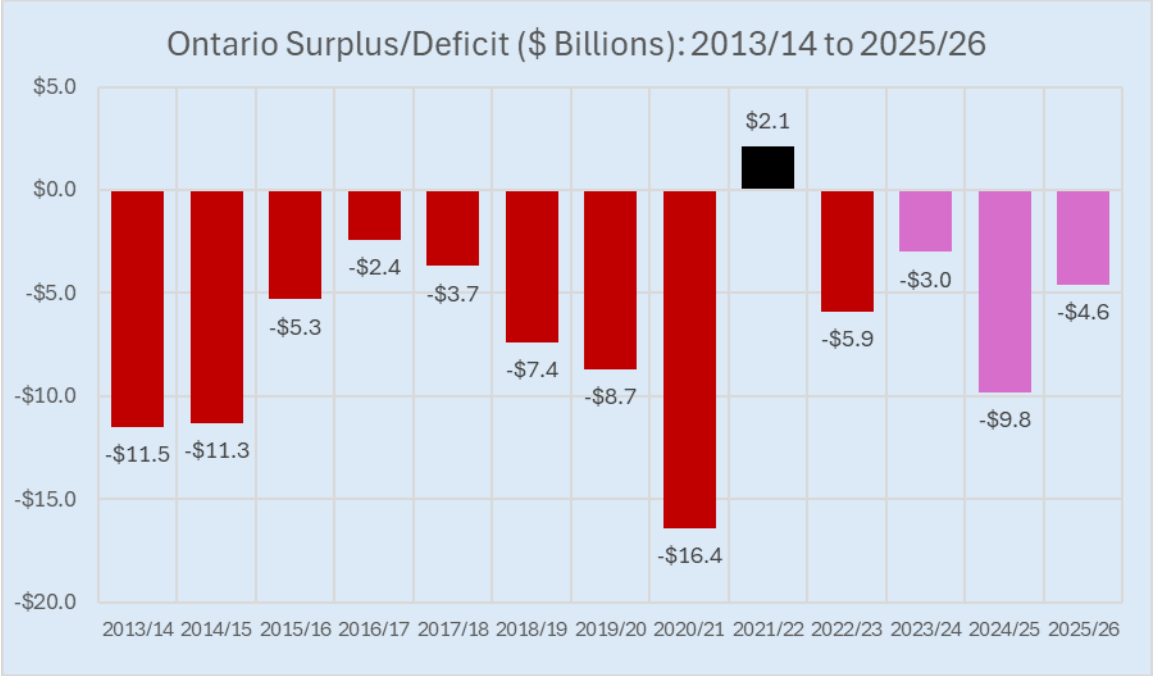
Sources: Statistics Canada Tables 10-10-0017-01, 17-10-0005-01, 10-10-0019-01 and FAO.

II. Budget Deficits and Surpluses

197. After experiencing a budget surplus of $2.1 billion in 2021-2022 towards the end of the pandemic,[129] the Government *is* projecting a deficit of $3.0 billion in 2023–24 in the 2024 Budget.[130] The government also projects a deficit of $9.8 billion in 2024-25, consistent with the increased investment it is making in services and infrastructure, improving to $4.6 billion in 2025-2026, before achieving a surplus of $0.5 billion in 2026-2027. This is consistent with the FAO's predictions that Ontario will be in a surplus position in 2026-27.[131]

198. Looking over the longer term, these deficit levels are consistent or lower than pre-pandemic levels:

[129] FAO Spring 2023 Outlook, supra at pp. 2-4, TAB 79 BOD VOL 3.
[130] 2024 Budget, *supra* at p 3, TAB 76 BOD VOL 3*;* Third Quarter Report, *supra,* TAB 85 BOD VOL 4.
[131] FAO Winter 2024 Outlook, *supra* at pp. 7-8, TAB 80 BOD VOL 3.



Source: Ontario 2024 Budget

199. When looking at the government budget projections, it is also important to consider that the government has a clear pattern of overstating how poor its fiscal position is and then revising those same predictions upwards in later financial statements when it suits its purposes. For example, in its 2023 Fall Economic Statement, the government projected a deficit of $5.6 billion in 2023–24.[132] Then, in its 2023–24 Third Quarter Finances, the government projected a deficit of $4.5 billion in 2023–24, an improvement of $1.1 billion compared to the outlook published in the fall of 2023. Now in its most recent 2024 Budget, it is projecting a deficit of $3 billion in 2023-24, *$2.6 billion less* than what it projected just five months ago.[133] Similarly, as noted, according to the 2024 Budget, revenues in 2023–24 are projected to be $204.3 billion, which is $1.6 billion higher than projected in Ontario's 2023-2024 Third Quarter Finances.[134] In other words, the government's deficit and revenue projections in its fiscal statements and Budget must be taken with a grain of salt.

[132] Ontario, Fall Economic Outlook, 2023, at p. 3, TAB 77 BOD VOL 3.
[133] 23-24 Third Quarter Report, *supra* at TAB 85 BOD VOL 4.
[134] 2024 Budget, supra at p 146, TAB 76 BOD VOL 3.

III. Positive Fiscal Sustainability Indicators

200. Another indicator of economic and fiscal health are the fiscal sustainability indicators that the government of Ontario itself uses, namely net debt-to-GDP ratio and interest on debt-to-revenue ratio, both of which are projected to remain comfortably below the government's target rates.

201. Net debt-to-GDP ratio "measures the relationship between a government's obligations and its ability to meet them, indicating the burden of government debt as a share of the economy"[135] The government's target for net debt-to-GDP ratio, as set out in the 2023 Ontario Budget is 40%.[136] As reported in the Ontario Fall Economic Outlook, the net debt-to-GDP ratio was 38.3% in 2022–23, 3.1% lower than forecasted in the 2022 Budget.[137] The FAO projects that the net debt-to-GDP ratio is expected to increase slightly to 38.7 per cent in 2024-25, before declining to 37.0% by 2027-28.[138] The 2024 Budget projects that the net debt-to-GDP ratio is expected to increase to 39.2% in 2024-2025, to 39.5% in 2025-2026 and reduce down to 39.1% in 2026-2027.[139] In its 2024 Budget, the Government further states that "[o]ver the medium-term outlook, the net debt-to-GDP ratio is forecast to stay below the target of 40.0%, demonstrating that Ontario continues to make positive progress towards reducing the debt burden, while remaining committed to the target originally set in the 2023 Budget."[140]

202. As reflected in the following chart, the projected ratios are in line with or better than how Ontario did in the pre-pandemic period:

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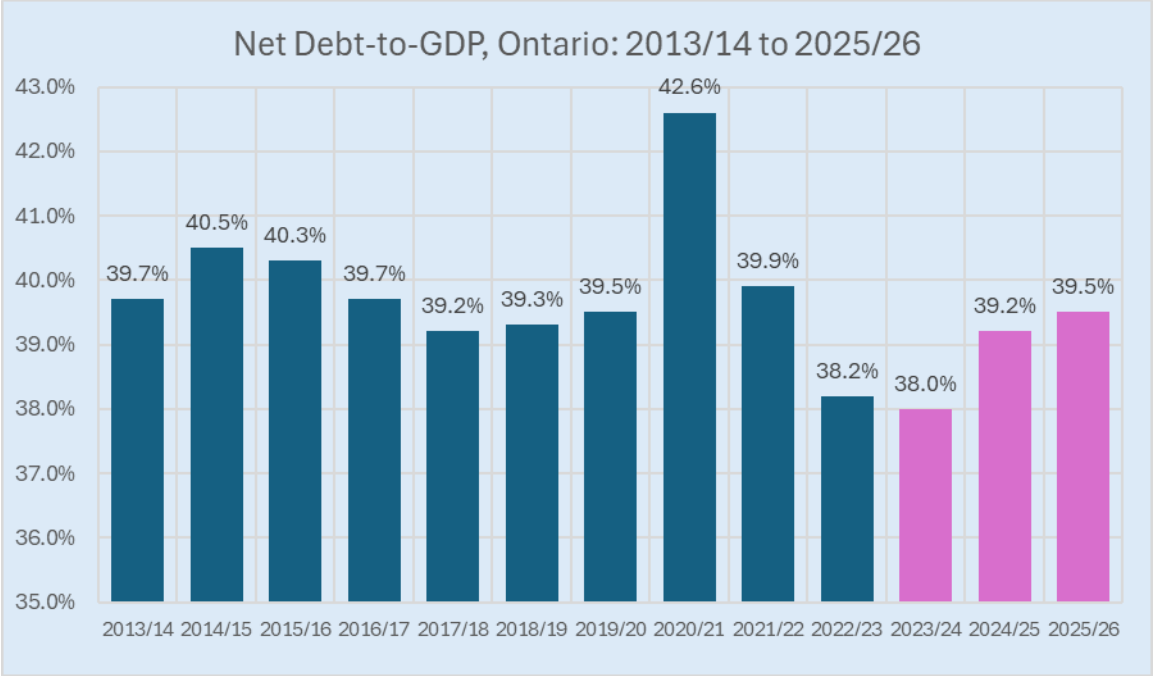
[135] 2024 Budget*, supra* at p 190, TAB 76 BOD VOL 3.
[136] *Ibid* at p 189.
[137] 23-24 Third Quarter Report, supra at p 109, TAB 85 BOD VOL 4. See also March 2023 Budget, supra at p. 174, TAB 84 BOD VOL 3.
[138] FAO Winter 2024 Outlook, supra, at pp. 8-9, TAB 80 BOD VOL 3.
[139] 2024 Budget, supra at p 190, TAB 76 BOD VOL 3.
[140] *Ibid.* at p. 74.



Source: 2024 Ontario Budget.

203. The interest on debt-to-revenue ratio is a measure of budget flexibility. According to David Dodge, the former Governor of the Bank of Canada and the Ontario government's expert in the Bill 124 *Charter* challenge, this ratio should be less than 10% to keep the province's economy healthy.[141] For 2022-2023, the debt to service cost ratio was 6.4% and it is forecasted to be 6.3% in 2023-2024[142] It is projected to be 7.0% in 2025-26, before declining to 6.8% by 2027-28, all very comfortably below the 10% threshold recommended by Dodge and accepted by the Ontario government. This too is much better than the ratios seen in the pre-pandemic period.

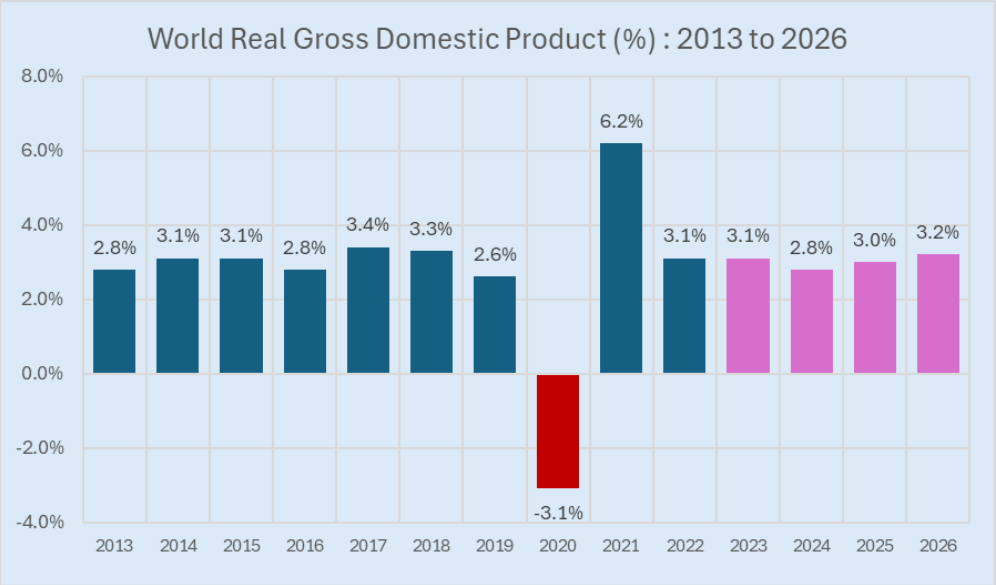
204. Thus, fiscal sustainability indicators are expected to remain below the government's targets of 40.0% for the net debt-to-GDP ratio and 10% for the interest on debt-to-revenue ratio for the PSA agreement period.[143]

[141] *OECTA, supra*, at para. 278, TAB 10 BOA.
[142] Fall Economic Outlook, *supra* at p. 105, TAB 77 BOD VOL 3.
[143] FAO Winter 2024 Outlook, *supra,* at pp. 8-9, TAB 80 BOD VOL 3.

205. In summary, according to the Government's own financial data and analysis, and as confirmed by the independent FAO, the Ontario economic and fiscal position remains on solid footing with positive projections heading into 2024-25.

IV. Continued Global Economic Growth

206. Along with Ontario's economic performance, the global economy is projected to show continued growth. In 2023, as set out in the FAO Winter 2024 Outlook, the global economy grew by an estimated 3.0% and is expected to expand further by 2025 "as inflation gradually returns to central bank targets and policy interest rates are lowered." Over the 2024 to 2028 period, the global economy is projected to grow by an average annual rate of 3.1% only slightly slower than the 3.4% average growth observed before the 2020 pandemic.[144] As reflected in the following chart, the projected global economic growth during the PSA period is consistent with growth in the pre-pandemic period:



Source: the World Bank (2013 - 2022); top Canadian Financial Institutions (2023-2026).

207. Similarly, the International Monetary Fund ("IMF") is predicting global growth of 3.1% in 2024 and 3.2% in 2025, with the "2024 forecast 0.2 percentage point higher than that in the October 2023 World Economic Outlook ("WEO") on account of greater-than-

[144] FAO Winter 2024 Outlook, *supra,* at p. 3, TAB 80 BOD VOL 3.

expected resilience in the United States and several large emerging market and developing economies, as well as fiscal support in China."[145] As well, global headline inflation is expected to fall to 5.8% in 2024 and 4.4% in 2025.

208. As a result, the global economy, like Ontario's economy is on stable footing at present with positive growth projections.

V. Private Sector Forecasts

209. Private sector economists also confirm better-than-expected economic growth and an economy that has proven to be resilient, robust, and stable and one which has avoided recession.

210. In the period leading up to the current context, private sector economists have confirmed very positive growth. For example, RBC, in its September 2022 Provincial Outlook, noted sustained growth in 2022, with "[g]oods-producing sectors continu[ing] to ride high on strong domestic and global demand [and] [h]ard-hit service industries rebound[ing] following the lifting of pandemic restrictions." This "vigorous economic activity" has in turn "led to a revenue windfall for provincial governments."[146]

211. Likewise, TD also commented on the strong economic performance domestically in 2022.[147]For 2023, private sector commentators have also noted that the "economy defied expectations in 2023"[148] and has proven to be very resilient and has out-performed expectations. Overall, the economy remains on stable footing.[149]

212. Looking forward to 2024 and beyond, while projections have moderated somewhat, private sector economists predicted continued growth. For example, Deloitte

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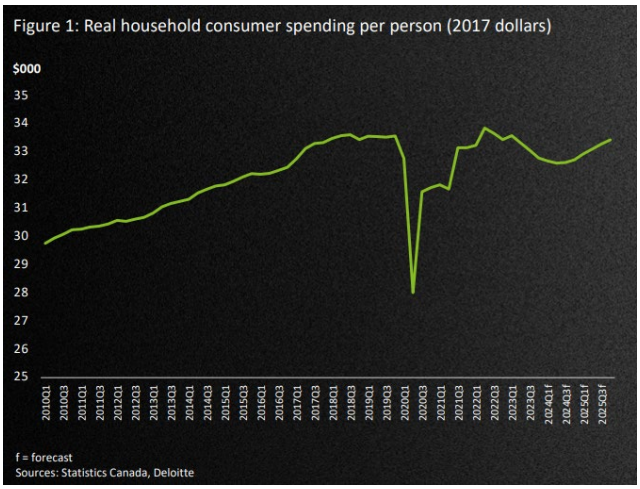
[145] International Monetary Fund, "World Economic Outlook Update, January 2024: Moderating Inflation and Steady Growth Open Path to Soft Landing" (January 30 2024) at p. 1, TAB 86 BOD VOL 4.
[146] RBC, Provincial Outlook – September 2022 ("RBC Outlook"), TAB 87 BOD VOL 4.
[147] TD, Canadian Quarterly Economic Forecast - Threading the Needle, September 20, 2022, ("TD 2022 Forecast") TAB 88 BOD VOL 4.
[148] TD, Canadian Quarterly Economic Forecast -Landing the Plane, December 14, 2023, ("TD 2023 Forecast"), TAB 89 BOD VOL 4.
[149] Pierre Cléroux, BDC, "Canadian economic outlook for 2024: Shifting into neutral" (December 08, 2023), TAB 90 BOD VOL 4.

reported on April 1, 2024 that "the economy ended 2023 with better-than-expected growth, the labour market has held up into 2024, and population growth remains robust" and that Canada is "poised to begin recovering from its current slump in the second half of this year."[150] In its view, Canada is achieving a "soft landing" and avoiding a recession while inflation returns to target. Deloitte also predicts that in 2025 growth will accelerate to 3%. As interest rates are reduced, cost to service debt loads will ease, resulting in more household spending and business investment. Continued strong population growth (1.25 million in 2023) will also support economic growth.[151]

213. Deloitte is further anticipating a return to pre-pandemic levels of real household consumer spending per person, as reflected in the following graph:[152]



214. While real GDP growth will be a modest 1% this year, Deloitte forecasts that the economy will accelerate in 2025, with anticipated real GDP growth of 2.9%. On the wage front, Deloitte reports that wage growth averaged 4.9% in 2023 in a tight labour market and is expected to hover around 5% before average weekly wages ease to a year-over-year pace of 2.9% by fourth quarter of 2024.[153]

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[150] Deloitte, "That was close: Canada looks set to dodge a recession" Economic Outlook, April 2024, TAB 91 BOD VOL 4.
[151] *Ibid.*
[152] *Ibid.*
[153] *Ibid*.

215. A further positive is that new real household disposable income is anticipated to gain 2.7% this year and real consumer spending predicted to be up 3.2% (inflation adjusted) in 2025. As well, new home construction will increase from 244,000 units in the first quarter in 2024 to 260,000 units in the last quarter of 2025.

216. There is also evidence of strong business investment in Ontario in 2024, including new investments in in the Volkswagen EV battery plant, NextStar Energy battery plant, and the Umicore facility.[154]

217. In a recent private sector analysis of the 2024 Ontario budget, RBC provides a forecast that is more positive than the government's. For example, RBC predicts that real GDP in 2024 and 2025 will be 0.5 and 2.2 respectively, higher than the government's assumptions of 0.3 and 1.9.[155] These differences are reflected in the following table:

Economic Growth Assumptions

	2023	2024	2025
Real GDP growth (%)			
Budget 2024	1.2	0.3	1.9
RBC	1.2	0.5	2.2
Nominal GDP growth (%)			
Budget 2024	4.1	2.7	3.9
RBC	4.3	3.6	4.4

Source: Ontario Ministry of Finance, RBC Economics

218. RBC also notes that, while expenditure in the recent budget is increasing, much of this spending is on needed infrastructure, including investments in the implementation of high-speed internet across all Ontario communities ($1 billion) and Ontario's new Municipal Housing Infrastructure Program ($1.8 billion over three years) which will

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[154] *Ibid*.
[155] Rachel Battaglia, RBC, "Provincial Budgets and Economic Statement – Ontario Budget 2024: Balancing priorities, not the books" (March 27, 2024), TAB 92 BOD VOL 4.

support core infrastructure projects including roads and water systems. [156] In other words, it is one-time necessary spending on infrastructure.

219. Thus, private sector economists confirm that the economic and fiscal outlook remains positive.

C. HEALTH CARE SPENDING

220. As reflected in the recent 2024 Ontario budget, the government has committed to increased investing in health care spending in a number of areas. At the same time, in contrast to other provinces, Ontario's health care spending is significantly behind and further and greater heath care investment by the government is needed.

221. According to the 2024 Ontario Budget, health sector expense is projected to increase from $84.5 billion in 2023–24 to $85 billion in 2024-25, $88 billion in 2025-26, and $89.9 billion in 2026–27, as the government responds to the needs of Ontario's growing and aging population, supports health human resource initiatives, improves the home and community care sector, improves quality of care in long-term care sector and supports mental health and addictions services. As set out in the medium-term expense outlook, these are significant increases over the actual health sector spending of $75.1 billion in 2022-2023 and of $69.6 billion in 2021-22.[157] In fact, over the last PSA, the Ontario government's health sector spending increased by 21.4%, or approximately 7% a year. In contrast, over the same period, the rate of compensation for physician fees increased by only 4.8%.

222. This increased health care spending includes an additional $546 million over three years to provide team-based primary care, building on the $110 million for interdisciplinary

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[156] *Ibid.*
[157] 2024 Budget*, supra* at pp. 157-158, TAB 76 BOD VOL 3; see also 2023 Budget, *supra* at pp. 139, TAB 84 BOD VOL 3.

primary care teams announced on Feb. 1, 2024. This additional funding is expected to provide team-based primary care to approximately 600,000 people.[158]

223. Recognizing that there is currently a shortage of family physicians, the Budget also includes investment in a new medical school in Vaughan at York University which will be "primarily focused on training family doctors."[159]

224. The government is also investing $50M over three years to enhance and stabilize health-care capacity within northern and rural communities. This investment will go towards improving recruitment, retention, education and care models to support residents in northern, remote and rural areas of Ontario.[160]

225. Other health sector funding of note in the budget, includes *inter alia* the following:

- an additional $2 billion in home and community care over three years to increase compensation for frontline care providers;
- $965 million, including a 4% increase in total base hospital operations, towards maximizing and expanding surgical procedures to lower wait times;
- funding to ease pressures faced by small and Northern hospitals to help address health human resources shortages, staffing costs, and emergency department closures;
- approximately $50 billion over ten years in health infrastructure, including close to $36 billion in capital grants, which will be put towards more than 50 hospital projects;
- $500 million over 10 years for small hospital projects and community health programs;

[158] *Ibid.* at p. 84
[159] *Ibid.* at p. 86.
[160] *Ibid.* at p. 88.

- $396 million over three years to improve access to and expand health and addictions services as well as continue the Addictions Recovery Fund;

- $155 million in 2024–25 to increase the construction funding subsidy, to support the cost of developing or redeveloping a long-term care home;

- $46 million over three years, starting in 2024–25, to support the continued operation of 59 Behavioral Specialized Unit ("BSU") beds in long-term care added in 2023–24, and to add more than 200 net new BSU beds to expand care for individuals with complex needs; and

- $12 million to establish a new Health Technology Accelerator Fund to help health care service providers buy and use promising new technologies to improve patient care. This fund will provide innovators, including Ontario-based companies, more opportunities to partner with the health-care system to promote early adoption.

226. The OMA submits that this increased funding in health care is a clear recognition by the government that greater investment is needed in health services. As central providers of these services, it is vital that there also be sufficient increased funding to support increases to the level of compensation received by physicians.

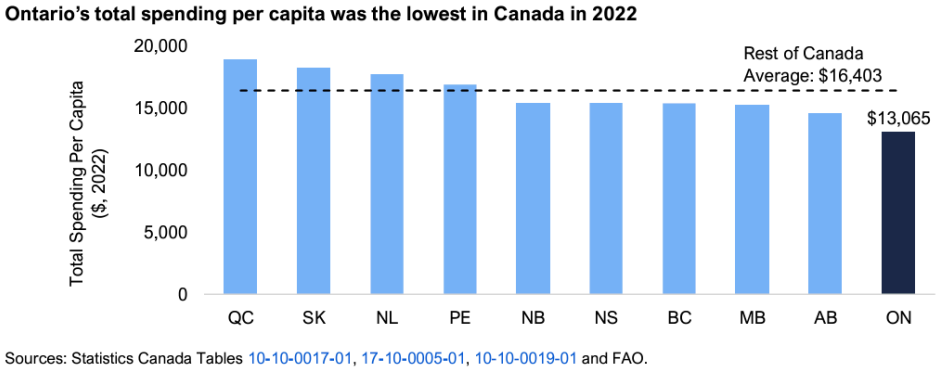
227. It should also be noted that federal funding for health care is also expanding. The Canada Health Transfer is expected to be $19.242 billion in 2023-24 increasing to $20.289 billion in 2024-25, the first year of the 2024-2028 PSA. Some of this new funding is to be targeted at the following shared priorities: family health services, health workers and backlogs, mental health and addiction, and a modernized health system,[161] many of which are priorities that overlap with some of the OMA's targeted proposals discussed below. Notably, Canada Health Transfers to Ontario have increased 55% since 2015-

[161] Jessica Mundle, "Federal, Ontario and Atlantic Canadian governments reach agreement on health-care funding" *CBC News* (February 23, 2023), TAB 93 BOD VOL 4.

2016, and 21.4% since 2021-22, the first year of the last PSA.[162] Unfortunately, very little of those increases have been directed to physicians by the MOH.

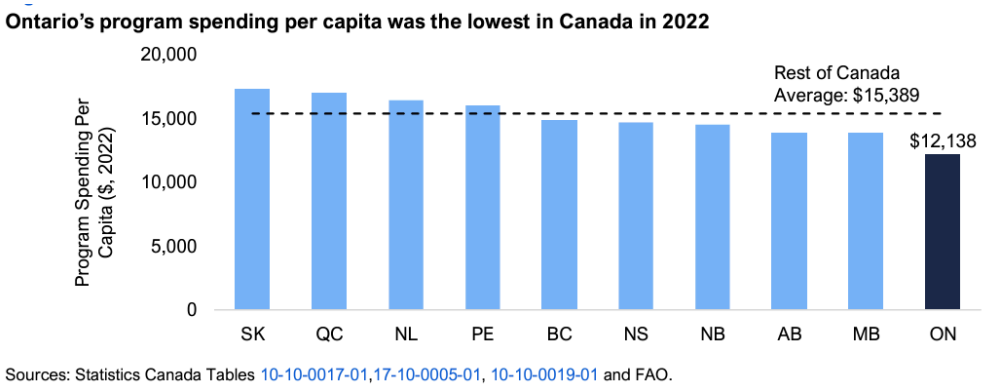
228. At the same time, while the 2024 Ontario budget reflects long-overdue increased health care spending, Ontario has for many years chosen to underfund health care services in the province.

229. According to the FAO, Ontario's program spending of $12,138 per capita in 2022 was the lowest among the provinces and $3,251 (21.1%) lower than the rest of Canada average ($15,389). The per capita total spending of all of the provinces in 2022 is set out in the following chart:[163]

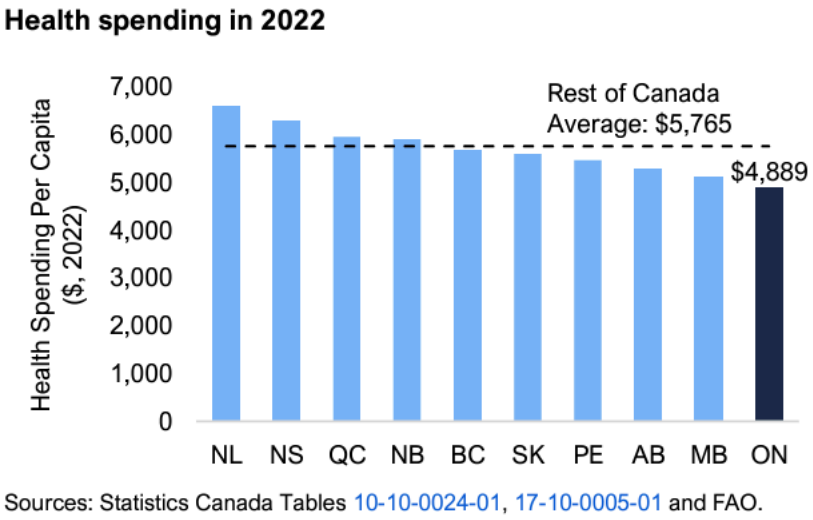


230. Similarly, Ontario's program spending per capita, was also the lowest in Canada in 2022, as reflected in the following chart:[164]

[162] Government of Canada, "Major Federal Transfers" (2023-12-15), TAB 94 BOD VOL 4.
[163] FAO Interprovincial Comparison, *supra,* at pp. 1, 8-9, TAB 78 BOD VOL 3.
[164] *Ibid.*



231. Most concerningly for present purposes, health spending per capita in Ontario was $4,889 in 2022, the lowest in Canada and $876 (15.2%) below the average of the other provinces.[165]



232. This underfunding of services is part of a long-term pattern. Since 2008, Ontario's total spending per capita has consistently ranked at or near the lowest among the provinces. As well, since 2008, Ontario's health spending per capita has consistently ranked at or near the lowest in Canada.

233. The OMA submits that the Ontario government cannot rely upon its choice to deliberately underfund the health care sector in Ontario to attempt to justify artificially low

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[165] *Ibid.*

compensation increases for physicians or to argue that the OMA's requested compensation increase is not sustainable. Indeed, when dealing with the public sector, arbitrators, including the chair of this Arbitration Board, have long recognized that individuals who choose to work in public services should never be expected to subsidize the provision of government services to the community by being paid sub-standard compensation.[166] Arbitrator Kaplan stated in the 2019 arbitration award between the parties that the government cannot "requir[e] Ontario doctors to subsidize public services".[167] Thus, the government's decision to underfund the health care system is not a basis for justifying artificially low compensation or compensation increases.

234. Given the importance of physician services to the health care sector, the recent increases to health care spending must also be shared with doctors in respect of the fees they receive for the medically necessary services they provide to the people of Ontario. The OMA submits that this investment by the government in health care, along with the stable economic and fiscal position of the province, is strongly favours its price increase proposals. Improvements in the provision of health care in this province must not be accomplished on the backs and out of the pockets of physicians.

[166] *General Truck Drivers and Helpers Union, Loc. 31 and British Columbia Railway Co.* (1 June 1976) (Arbitrator Owen Shime) (unreported), TAB 12 BOA.
[167] 2019 Kaplan Arbitration Award, *supra* at p. 8, TAB 1 BOA.

PART SEVEN - PHYSICIAN RECRUITMENT AND RETENTION

235. Another significant justification for the OMA's proposal is the extent to which Ontario is facing a physician human resources crisis. The evidence of this is everywhere. It can be seen, for example, in the unprecedented number of patients unattached to a family physician, the closures and crowding of emergency departments, the long wait lists to see a specialist, and the backlog of surgical procedures and diagnostic imaging in the post-pandemic era.

236. As the Ministry's own nominee to the Board acknowledges in a recent editorial:[168]

> [W]e cannot train and retain enough doctors to meet the growing health needs of Canadians. Our hospitals are struggling with long wait times and nursing and other clinician shortages. Every year, we have more people who need more care.

237. This crisis is particularly acute in certain regions of the province, such as the North, and specific practice areas, including family medicine, emergency department coverage, internal and occupational medicine, pediatrics, psychiatry, cardiac paediatric surgery, and anesthesiology, amongst others. However, concerns about physician recruitment and retention are found in all regions and specialties.

238. If left unaddressed, this physician human resources crisis will only get worse in the coming years. While the system was already under strain pre-pandemic, the problems were further exacerbated by the COVID-19 pandemic. As well, a growing and aging population, more physicians retiring, increasing complexity of care and shifting hours of work will only increase the extent of the current crisis.

239. While increased compensation is not the sole solution to recruitment and retention problems, it is a vital and essential part of it. As reflected in the arbitral case law, "*there*

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[168] Dr. Adalsteinn Brown and Dr. Kevin Smith, "We need to revolutionize how we organize health care in Canada," *Toronto Star* (April 19, 2024), TAB 95 BOD VOL 4.

is no question that compensation is a key driver in attracting and retaining ...employees."[169]

A. EVIDENCE OF PHYSICIAN SHORTAGES

240. The OMA submits that there is compelling evidence of physician shortages throughout the province and in many practice areas at present.

241. One such source of data is the Physician Resources Integrated Model ("PRIME"), developed by the OMA to help improve physician workforce planning in Ontario. PRIME uses the census data of all 14,223,942 Ontario residents who were alive at any time between April 1, 2021 and March 31, 2022 and who were eligible for the Ontario Health Insurance Plan ("OHIP") during this period. For each Ontario resident, the number of annual visits from physicians in each specialty is calculated using the OHIP Claims Database. The relationship between the number of annual visits and patients' characteristics is then estimated and the utilization of physician services by each patient to the level of care achieved in a benchmark population is compared. Finally, the relative shortages in physician services as the difference between what patients currently receive and what they would have received based on their needs only (i.e. if their socioeconomic variables were the same as in the benchmark population) is calculated.

242. These relative shortages can be used to estimate the current gap in physician services if the level of care in the benchmark population is interpreted as the minimum level of care required to meet the unique needs of patients. The physician workforce requirements to close this gap are then those required to bring all patients in the province to at least the level of care received in the benchmark community.[170]

243. Using this approach, there was an estimated shortage of 2,033 physicians in the province of Ontario in fiscal year 2021, with acute shortages in Family Practice,

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[169] *Participating Hospitals v OPSEU, 2023 CanLII 75478 (ON LA),* TAB 13 BOA (emphasis added).
[170] OMA, OMA Physician Resources Integrated Module (1.0): Short Term Module, 2024, TAB 96 BOD VOL 4.

Emergency Medicine, Internal and Occupational Medicine, Paediatrics, Psychiatry, and Anaesthesiology. These shortages are set out by specialty in the following table:[171]

	SHORT-TERM GAP		
Specialty	**Total services (#)**	**Total services (%)**	**Total MDs**
Anaesthesiology	115,629	7.45%	103.8
Cardiac Surgery	32,624	21.58%	18.9
Cardiology	384,838	10.44%	63.4
Dermatology	145,820	13.19%	27.1
Diagnostic Radiology	273,695	2.06%	25.2
Emergency Medicine	574,096	11.47%	247.2
Endocrinology & Metabolism	122,839	18.34%	27.5
Family Practice & Practice in General	1,675,514	5.46%	455.5
Gastroenterology	62,810	12.37%	21.6
General Surgery	115,223	7.53%	52.5
General Thoracic Surgery	16,973	20.34%	6.7
Geriatrics	56,183	31.26%	46.2
Haematology	83,301	15.13%	25.3
Infectious Diseases	40,298	18.74%	26.7
Internal and Occupational Medicine	439,073	9.83%	152.4
Medical Oncology	79,631	11.26%	19.0
Nephrology	101,826	13.28%	24.1
Neurology	53,427	9.51%	31.6
Neurosurgery	18,970	12.33%	12.0
Nuclear Medicine	75,585	38.64%	21.0
Obstetrics & Gynaecology	177,279	6.27%	52.6
Ophthalmology	128,445	4.81%	23.2
Orthopaedic Surgery	118,933	7.12%	44.4
Otolaryngology	61,251	6.91%	17.1
Paediatrics	382,958	14.17%	182.4
Physical Medicine & Rehabilitation	101,222	19.94%	43.6
Plastic Surgery	71,136	12.00%	29.6
Psychiatry	182,895	11.75%	142.1
Radiation Oncology	21,403	9.48%	13.2

[171] *Ibid.*

Respiratory Disease	98,721	14.71%	31.4
Rheumatology	65,888	11.53%	18.8
Urology	55,545	7.02%	14.2
Vascular Surgery	49,329	15.83%	12.4
Grand Total	**5,983,359**	**7.30%**	**2,032.9**

244. Another source of data is job posting vacancies. The Canadian Medical Association compiled data regarding job postings for physician full-time permanent positions, excluding locums and part-time positions, by Province/Territory and Specialty as of December 2022. As not all available positions are advertised, this analysis in fact understates the actual number of available positions.[172]

245. According to this data, there were 1,411 full-time permanent physician positions open in Ontario as of December 2022, including 773 family medicine positions and 519 medical specialists.[173]

246. This data also reveals troubling gaps between the number of job openings in various specialties versus the number of graduates from training programs. For example, in December 2022 there were over 400 psychiatry opportunities in Canada, whereas in 2021 there were only 204 graduates from psychiatry training programs.[174]

247. Similarly, in December 2022, there were full-time postings for 5,099 physicians in all of Canada but only 3,470 postgraduate exits in 2021. As well, many of the postings had remained unfilled for months.[175]

248. According to data from Health Force Ontario for 2024, there are vacancies for more than 3,000 full-time, part-time and locum physicians across the province, as set out below:[176]

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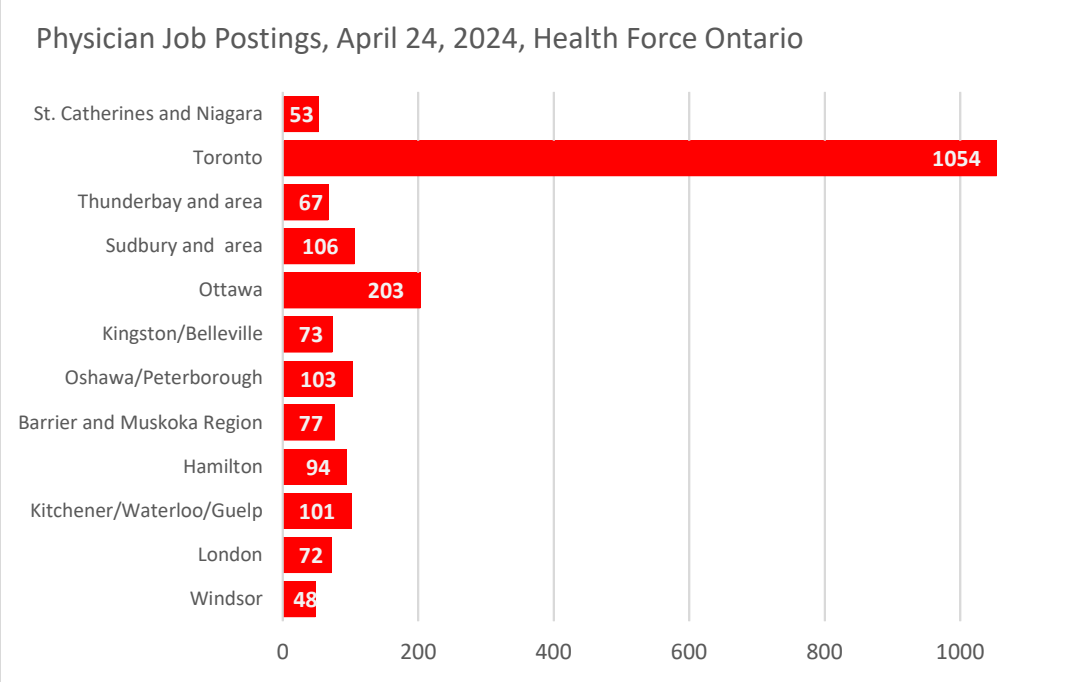
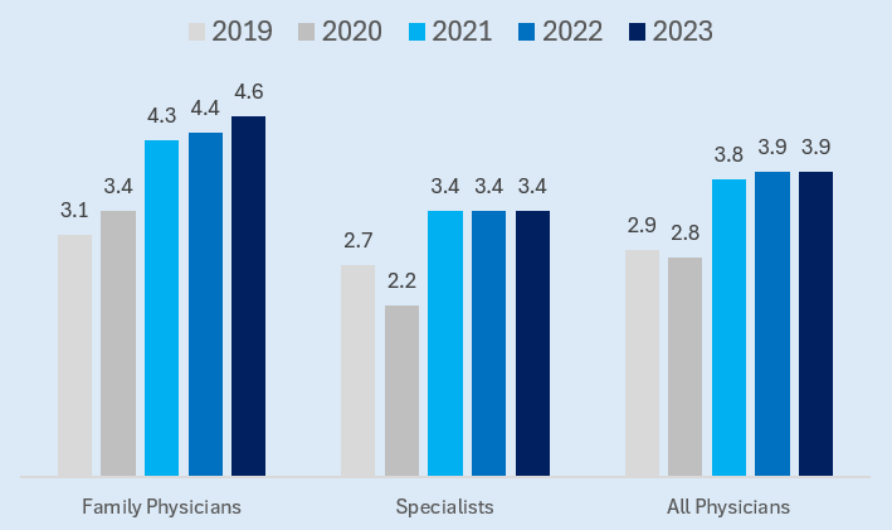
[172] CMA, "Physician Opportunities in Canada," TAB 97 BOD VOL 4.
[173] *Ibid.*
[174] *Ibid.*
[175] *Ibid.*
[176] Data Source: Health Force Ontario, https://hfojobs.healthforceontario.ca/en/map/?p=1. See also Ryan Patrick Jones, "Family doctor shortage affects every region and is getting worse, Ontario Medical Association says" (Jan 29, 2024), TAB 98 BOD VOL 4.



249. As well, as set out in the following chart, when one compares the physician job opportunities advertised through the Health Force Ontario, the marketing and recruitment branch of Ontario Health, from before the pandemic to post-pandemic, the shortage of physicians is proportionately higher than it was in the pre-pandemic era by about 1% of total physician workforce.

Physician Job Opportunities, 2019 to 2023, Ontario (% of total physicians)

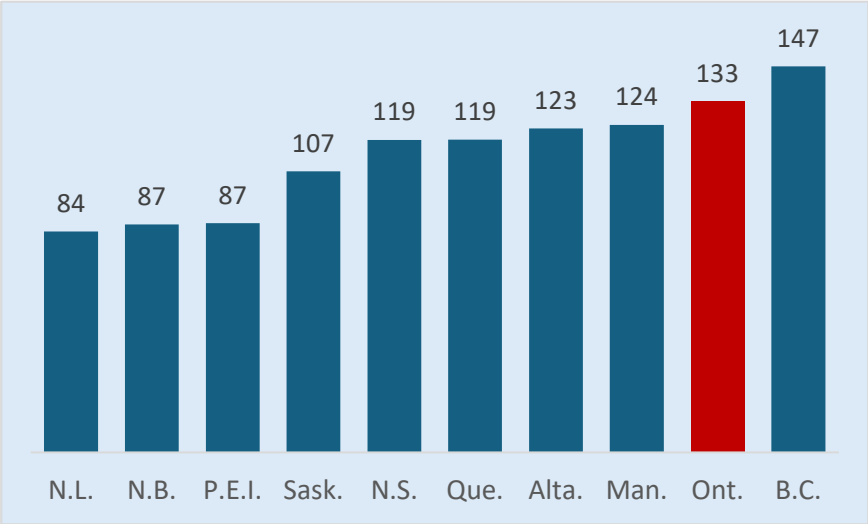


Source: Canadian Medical Association. Physician Opportunities in Canada. As of December of each year. Excludes locums and part-time.

Year	Family	Specialists	All
2019	520	468	988
2020	578	375	953
2021	745	592	1,337
2022	773	607	1,380
2023	669	707	1,376

250. In general, the supply of physicians in Ontario relative to other provinces has been dropping in recent decades. In 1971, the first year for which the data is available, Ontario had the second highest physician to population ratio in Canada, as depicted in the following chart:

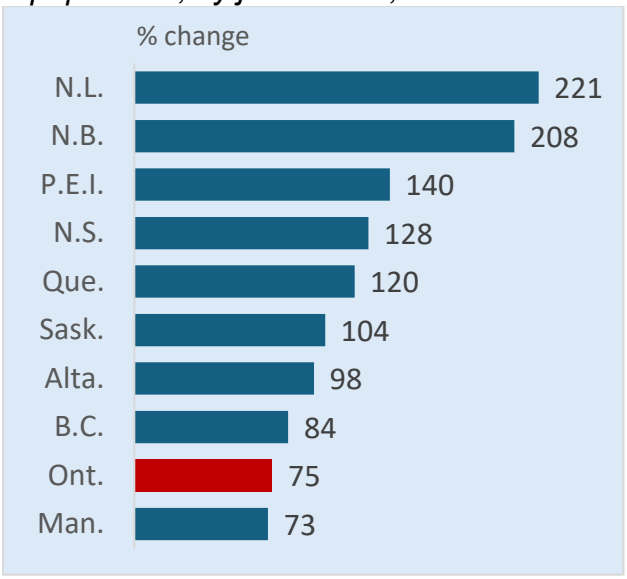
Number of total physicians per 100,000 population, by jurisdiction, Canada, 1971



Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023.

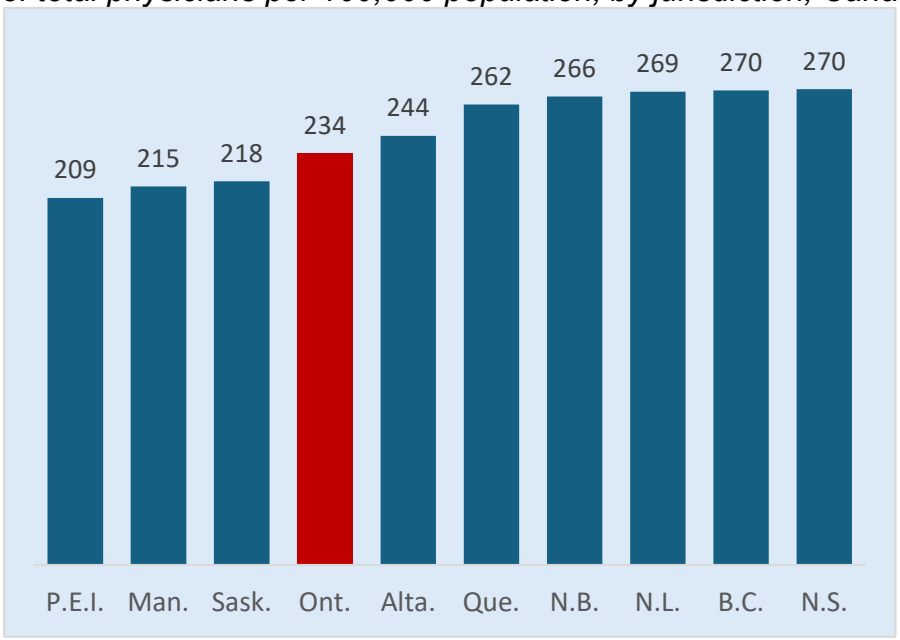
251. Since then, Ontario has had the second lowest growth in the number of physicians per population:

Percentage Change in the number of physicians per 100,000 population, by jurisdiction, Canada. 1971 to 2022



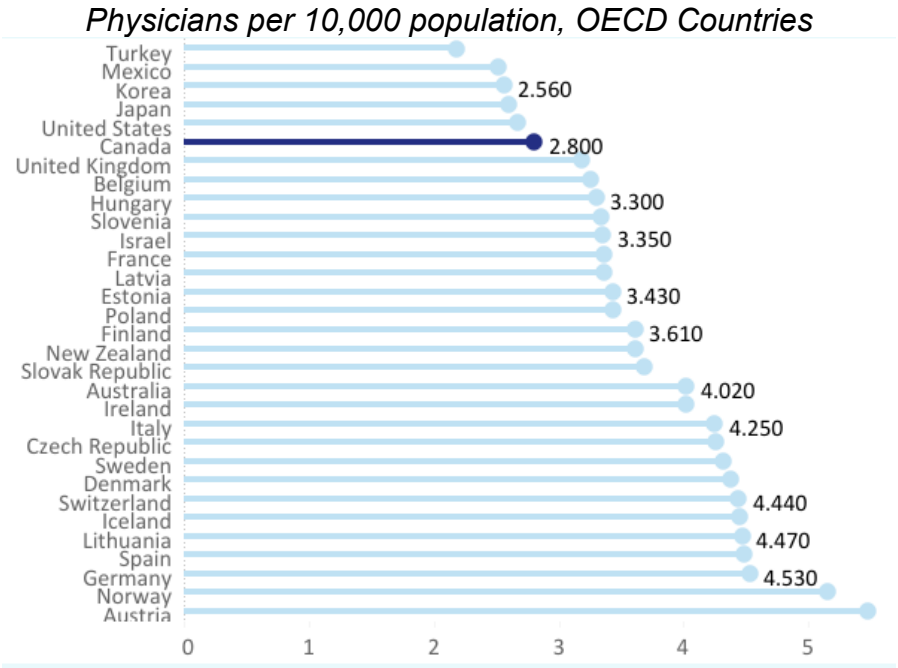
252. As a result, Ontario has gone from one of the provinces with the highest physician to population ratios in the country to one of the lowest, as seen in the following chart:

Number of total physicians per 100,000 population, by jurisdiction, Canada, 2022



Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Data Tables. Ottawa, ON: CIHI; 2023. Table 23.0.

253. In turn, Canada has one of the lowest physician to population ratios among OECD countries:



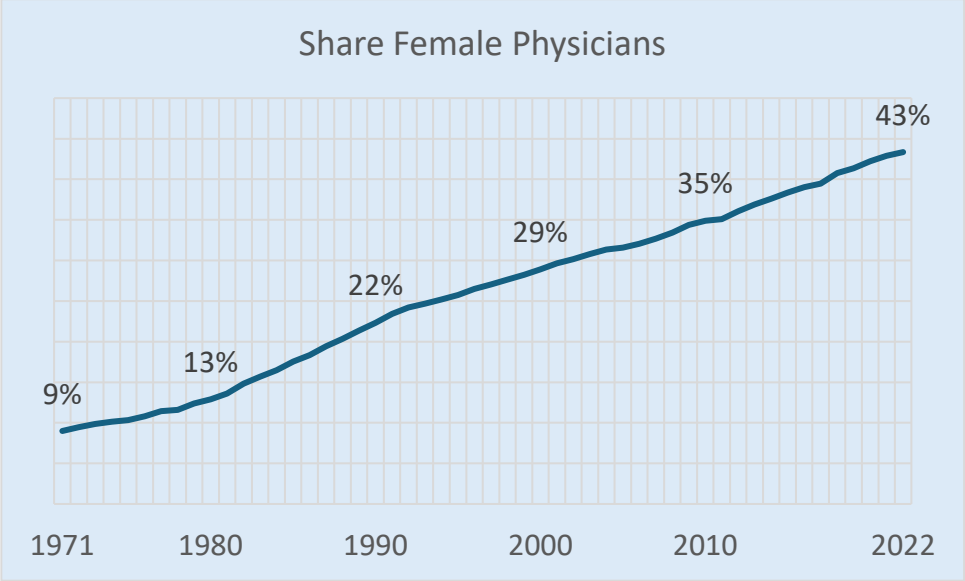
Source: Organisation for Economic Co-operation and Development ("OECD"). 2023.Doctors (indicator). doi: 10.1787/4355e1ex-en (Accessed on 24 October, 2023).

254. Within Ontario, there is also significant variation in the number of physicians per 1000 population. Whereas there are 4.7 physicians per 1,000 people in Toronto, there are only 1.8 to 2.2 physicians per 1,000 people in other Ontario health regions as of 2021.[177]

[177] Data Source: The Ontario Physician Reporting Centre. 2022 Physicians in Ontario Annual report – Hamilton, ON: OPRC; 2023; and Statistics Canada. Table 17-10-0134-01 Estimates of population (2016 Census and administrative data), by age group and sex for July 1st, Canada, provinces, health regions (2018 boundaries).

255. In addition to the inadequate growth in physician supply, the number of female physicians has been steadily increasing over time, a demographic change which has also impacted the level of service provision.

Change in Physician Workforce Demographics, 1971 to 2022, Ontario



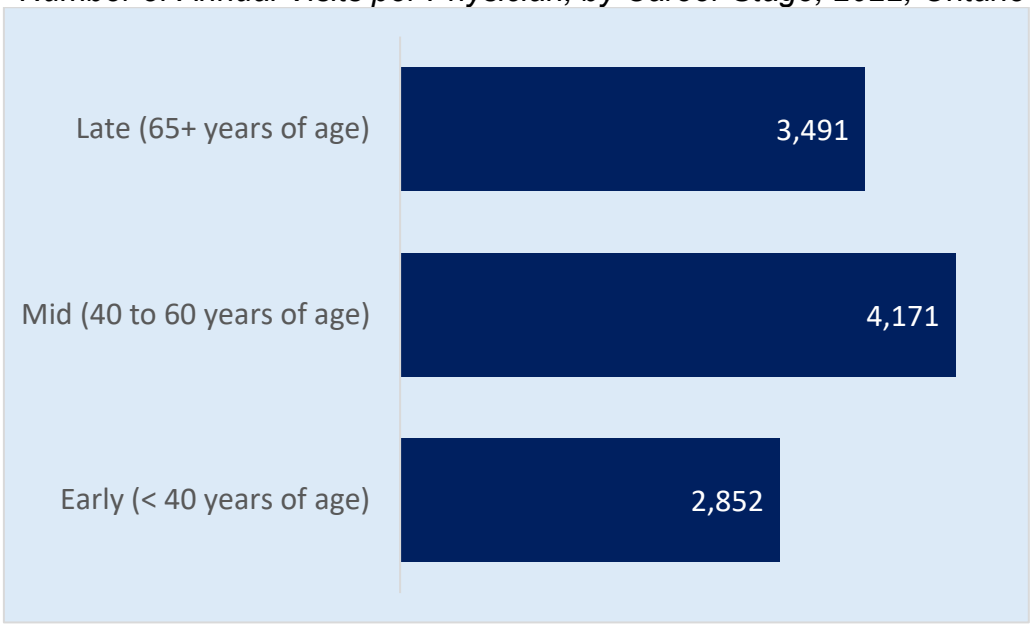
Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023. Table 1.

256. According to Flood et al, "female physicians wor[k] fewer hours than their male counterparts, and having fewer patient encounters but, on the other hand, spen[d] more time with their patients and dea[l] with more issues within a given visit." Pregnancy, childbirth, and child-rearing obligations are also important contributing factors.[178]

257. Similarly, as can been seen in the following chart, early career physicians (forty years of age or less) conduct fewer annual visits than mid (40 to 60 years of age) or late (65+ years of age) career physicians.

[178] Flood *supra*, TAB 14 BOD VOL 1.

Number of Annual Visits per Physician, by Career Stage, 2022, Ontario



Source: Ontario Health Insurance Plan ("OHIP") Claims Database. Fiscal year 2022-23.

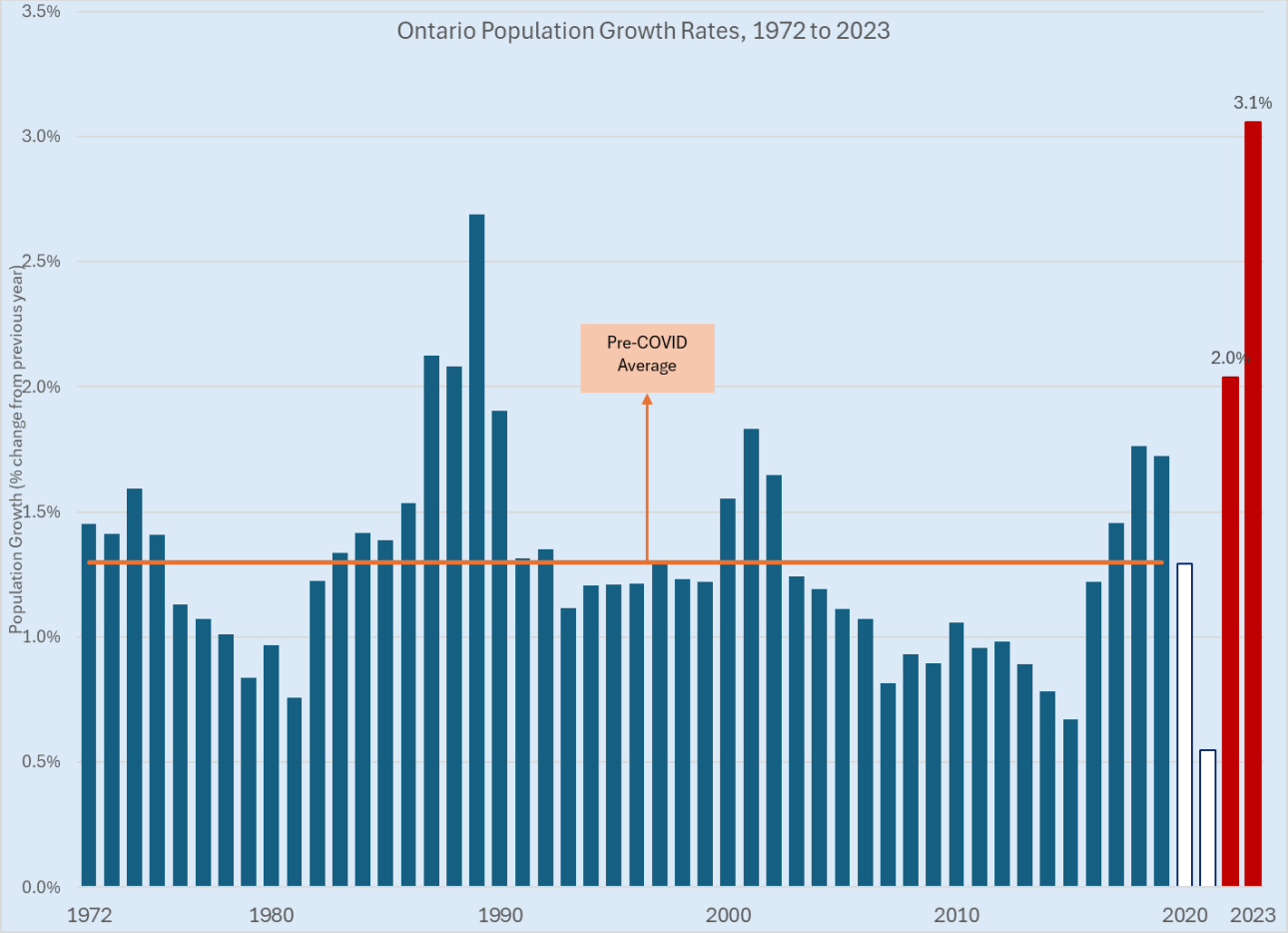
258. Due to all these demographic changes, the number of visits per average physician has decreased since 2010 by about 4%, also contributing to the overall shortage of physicians in the province.

259. Thus, there is clear and compelling evidence of generalized physician shortages throughout the province and as well as specific shortages in many practice areas.

B. THE PHYSICIAN HUMAN RESOURCE CRISIS IS GETTING WORSE

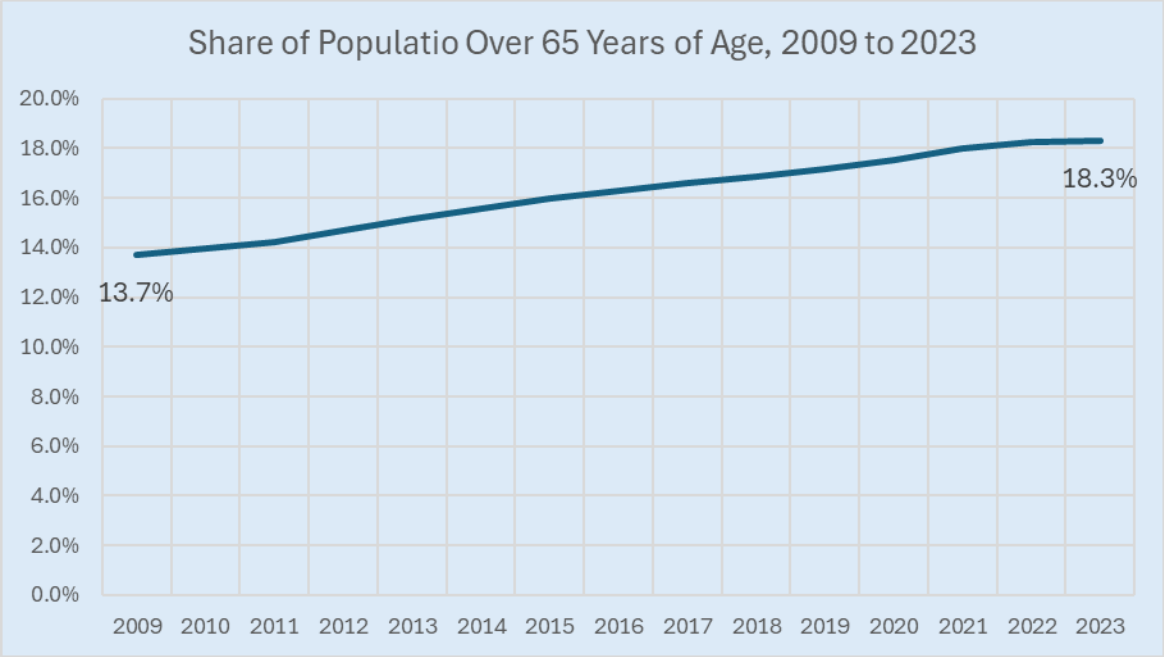
260. Compounding the existing problems, experts predict that the physician human resource problem is only going to get worse if left unaddressed as a result of a growing and aging population, more physicians retiring, increasing complexity of care and shifting hours of work.

261. Contributing to the worsening problem is the fact that there has been significant population growth in Ontario. As seen in the following chart, in 2022 and 2023, Ontario has experienced the highest population growth in the last 50 years. A half million new Ontario residents in 2023 is the highest increase on record since Confederation.



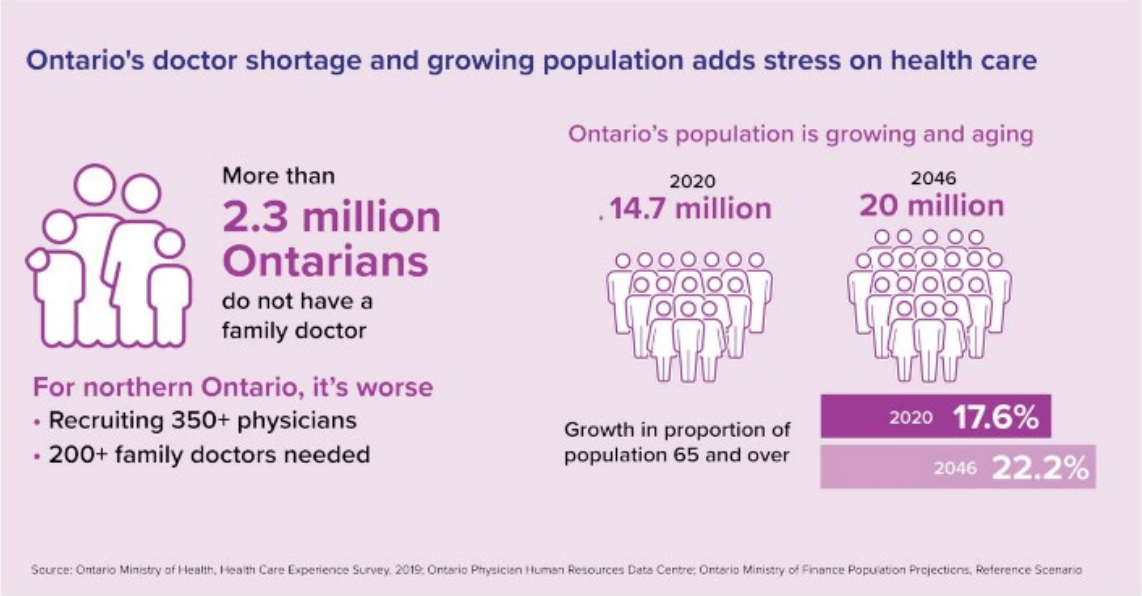
Source: Statistics Canada, CANSIM Table 17-10-0009-01.

262. At the same time, the proportion of Ontario residents over 65 years of age has been steadily increasing over time, placing additional demands on physician resources:



Source: Statistics Canada, Table 17-10-0005-01 Population estimates on July 1, by age and gender.

263. Whereas the proportion of the population 65 and over was only 17.6% of the total population in Ontario in 2020, by 2046, it is anticipated that it will be 22.2% of the population. Notably, as summarized in the infographic below, this is coupled with Ontario's physician shortage, resulting in more than 2.3 million Ontarians not having a family doctor:



264. In addition, a recent study[179] using the Canadian Institute for Health Information ("CIHI") Population Grouper has documented that the prevalence of multiple chronic conditions in Ontario is growing, with 'minor' or 'moderate' conditions slightly declining while 'major' conditions are increasing. Overall, the age-sex standardized patient resource intensity is increasing over time by about 0.5% each year.

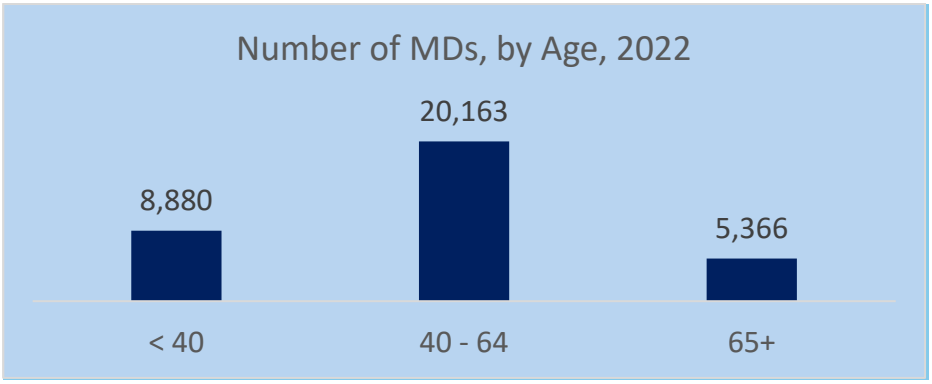
265. Consistent with these findings, Islam et al. have similarly found that, when population aging and changing physician hours of work are accounted for, while the absolute physician-to-population ratio has increased between 1987 and 2019, the adjusted physician-to-population ratio is in fact 4% lower.[180]

266. As a result of these demographic and epidemiological changes, the demand for physician services is expected to continue to grow. During the 2019 Arbitration, the Parties agreed that the long-term utilization was about 3.6%. At the time, the OMA presented a detailed breakdown of drivers of utilization, with the population growth being

[179] Steffler M, Li Y, Weir S, Shaikh S, Murtada F, Wright JG, Kantarevic, J. *Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada*. Canadian Medical Association Journal. 2021 Feb 22;193(8): E270-7, TAB 22 BOD VOL 1.
[180] Rabiul Islam, Boris Kralj and Arthur Sweetman, "Physician workforce planning in Canada: the importance of accounting for population aging and changing physician hours of work" *CMAJ* March 06, 2023 195 (9) E335-E340 at E335, TAB 99 BOD VOL 4.

at its historical average at 1.4%. However, due to higher population growth both in the past year, and projected in future years, demand for physician services is reasonably expected to grow over the course of the 2024-28 PSA by more than 3.6%.

267. At the same time as there are increasing demands for physician services, the number of physicians retiring is also anticipated to grow. As of 2022, 74.2% of physicians in Ontario were over age 40 and 15.6% were over age 65:[181]



268. For many, the strain of the COVID-19 pandemic contributed to a decision to leave practice. For example, the "number of Ontario family physicians leaving the profession in the first half of 2020 was three times the normal number" with "some retiring and others shifting to potentially less stressful fields."[182]

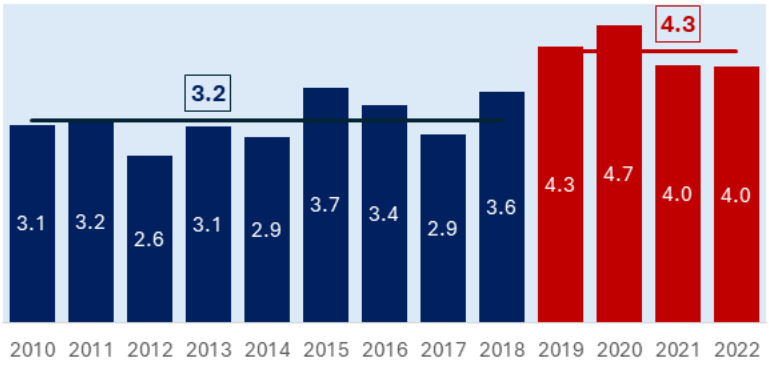
269. This trend however is continuing post-pandemic. Based on the OMA's own survey of its members, 40% of Ontario physicians are considering retiring in the next five years. Members report that the impetus for their considering retirement includes income not keeping up with inflation and the ever-increasing administrative burden with "family

[181] Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2022) - Hamilton, ON: OPRC; 2024.
[182] Flood CM, Thomas B, McGibbon E., "Canada's primary care crisis: Federal government response," *Healthcare Management Forum*, 2023;36(5):327-332 at 327, TAB 14 BOD VOL 1.

doctors report[ing] spending 40% of their work week on completing forms and trying to navigate patients through a system that is disconnected and fragmented."[183]

270. The exit of physicians is well underway. For example, the proportion of physicians leaving practice in Ontario in the post-pandemic era is almost one full percentage point higher than in the pre-pandemic era, as seen in the following chart:

Percent Physicians Exiting from Active Practice, Ontario, 2010 to 2022



Source: Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2022) - Hamilton, ON: OPRC; 2024

271. All of this points to a physician human resource shortage in Ontario which will only grow worse in the coming years if something is not done to address it.

C. THE PHYSICIAN HUMAN RESOURCE CRISIS IS ACUTE IN FAMILY MEDICINE

272. In the area of family medicine, the crisis is particularly acute and evidence of physician shortages is everywhere. As noted in the following chart, as of September 2022, the number of unattached patients in Ontario was about 2.3 million, or about 15% of total population:

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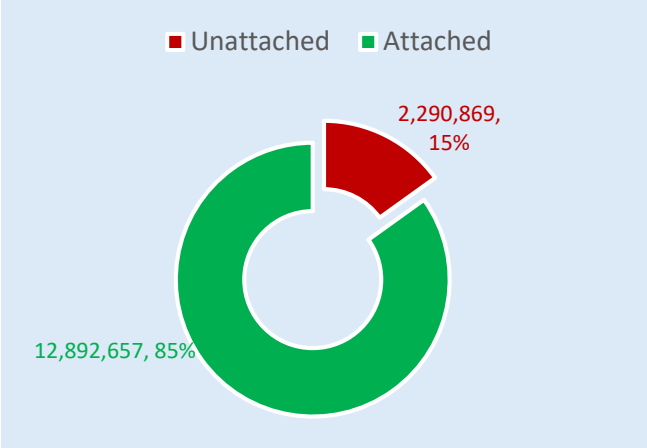
[183] Ryan Patrick Jones, "Family doctor shortage affects every region and is getting worse, Ontario Medical Association says" (Jan 29, 2024), TAB 98 BOD VOL 4. See also OMA Prescription Survey, *supra,* at p. 33, TAB 19 BOD VOL 1; OMA, *Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care* (October 26, 2021) at pp 16-18, TAB 100 BOD VOL 4; Ontario College of Family Physicians, "Without urgent action, nearly 1 million in Toronto could be without a family doctor by 2026" (March 5, 2024) ["OCFP Urgent Action"], TAB 101 BOD VOL 4; Kelly Grant, "Almost 20 per cent of Toronto doctors are considering closing their practice in the next five years," *Globe and Mail* (November 14, 2022), TAB 102 BOD VOL 4.

Attachment Status of Ontario Patients, 2022



Source: Ontario Community Health Profiles Partnership, Ontario Health Teams ("OHTs") (ontariohealthprofiles.ca).

273. By 2025, it is anticipated that more than three million Ontarians will be without a family doctor.[184] By 2026, that number could be as high as 4.4 million, as physicians retire or scale back in the next few years.[185]

274. Alarmingly, in 2024 the number of vacant family medicine spots after the first round of residency matching in Ontario was higher than in previous years. According to CaRMS data, there were "108 unfilled family medicine spots out of a total of 560 in Ontario following the first round of this year's match, up from 103 unclaimed spots last year." This is an increase from 100 in 2023, 61 in 2022, 52 in 2021 and 30 in 2020. As well, consistent with a decline that has been seen for many years, only 30% of graduates ranked family medicine as their first choice for their specialty training, down from 38% in 2015.[186]

275. This evidence is also confirmed by the academic literature, which reports that "[o]ne in six Canadians report not having a regular family physician, and less than half of Canadians are able to see a primary care provider on the same or next day."[187]

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[184] Kelly Grant, "More than three million Ontarians could be without a family doctor by 2025," *Globe and Mail* (September 13, 2022) TAB 103 BOD VOL 4.
[185] OCFP Urgent Action, *supra,* TAB 101 BOD VOL 4.
[186] Ryan Patrick Jones, "Physicians sound alarm over unfilled Ontario residency spots" *CBC News (*March 24, 2024), *supra* at TAB 16 BOD VOL 1.
[187] Flood CM, Thomas B, McGibbon E., "Canada's primary care crisis: Federal government response," *Healthcare Management Forum*, 2023;36(5):327-332 at 327, TAB 14 BOD VOL 1.

276. Problematically, family physicians are the slowest growing category of new physicians in Canada. According to Flood et al., the shortage can be explained by higher earning potential of other specialities and the fact that a large number of physicians in Canada are nearing retirement age, and that "a single retirement can leave nearly 1,000 patients without a family doctor."[188]

277. These troubling findings are also confirmed by the OCFP who similarly report that 2.3 million people did not have a family doctor in Ontario as of 2024.[189]

278. According to the OCFP, there are several factors contributing to the shortage, including challenges in retaining family doctors and "system-wide issues including overwhelming administrative burden, lack of team supports and compensation that has not kept pace with inflation."[190] The OCFP also reports that 65% of family doctors plan to leave or change their practice in the next five years.[191]

279. As reported by Li et al., when comparing data across Canada, the shortage of family physicians is particularly acute in Ontario. With only one family physician per 1,010 people, Ontario has the worst ratio of population per family physician in the entire country.[192]

280. As reflected in the chart below, according to the Canadian Institute for Health Information,[193] Ontario has one the lowest shares of family physicians by province:

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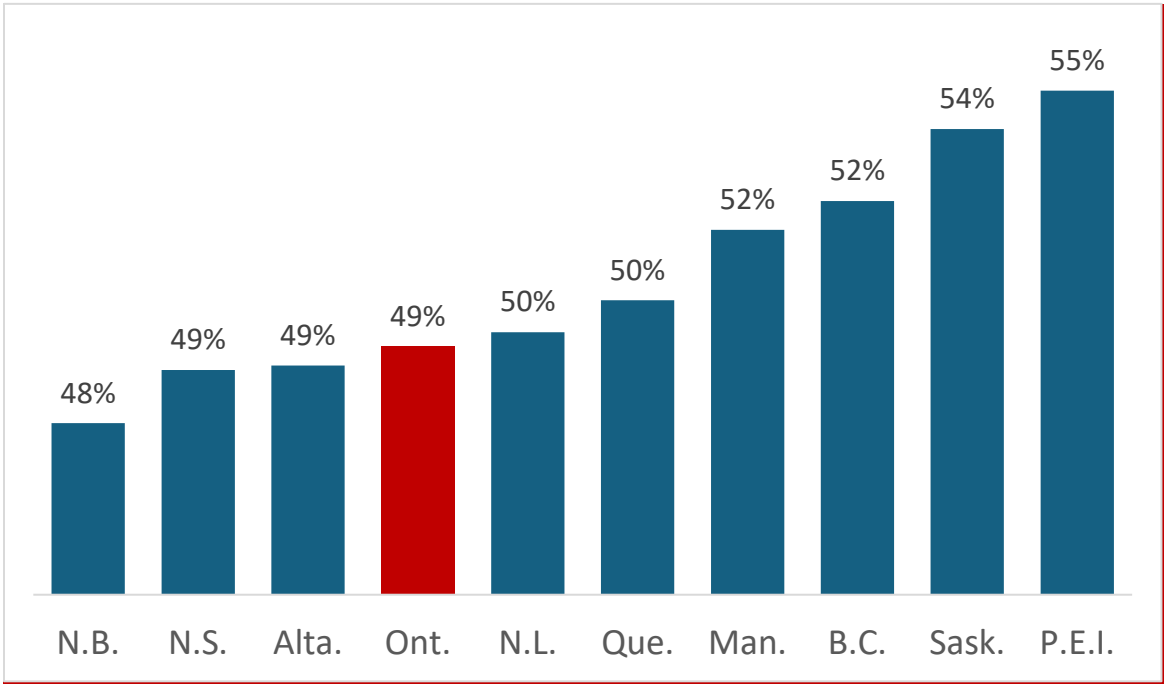
[188] *Ibid.*
[189] OCFP Urgent Action, *supra,* TAB 101 BOD VOL 4.
[190] *Ibid.*
[191] *Ibid.*
[192] Li K, Frumkin A, Bi WG, et al. "Biopsy of Canada's family physician shortage," *Fam Med Com Health* 2023;11:e002236, pp. 1-4 at p. 2, TAB 11 BOD VOL 1.
[193] Data Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Data Tables. Ottawa, ON: CIHI; 2023.



281. Li et al. also confirm that the shortage of family physicians is related to the "stagnation of wages, inflation and a decrease in government investment in primary care at the federal and provincial levels."[194] This family physician shortage will only get worse as a result of "growing and ageing population, coupled with increased patient care complexity and a higher prevalence of chronic health issues," along with the fact that "up to 20% of FPs planning to retire in the next 5 years" and the fact that fewer medical graduates are choosing family medicine.[195]

282. Of added concern is the fact that older family physicians also have the largest rosters of patients. Specifically, family physicians over age 50 have rosters of 1,370 plus patients on average. In contrast, family physicians under the age of 40 have rosters of 986 patients on average. In other words, as the older physicians retire, a higher proportion of patients will be left without primary care.[196]

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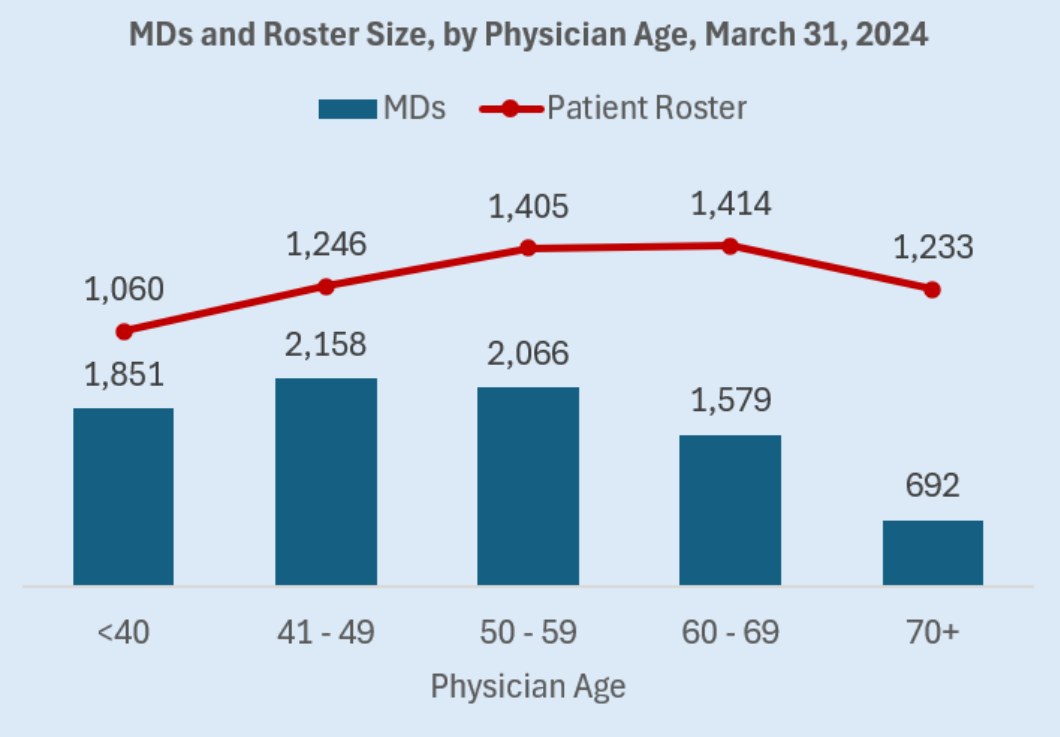
[194] *Ibid.* at p. 1.
[195] *Ibid.*
[196] Data Source: Ontario Ministry of Health: Corporate Provider Database, Registered Persons Database, Client Agency Program Enrolment, Ontario Health Insurance Plan.


MDs and Roster Size, by Physician Age, March 31, 2024
MDs
Patient Roster
1,060
1,246
1,405
1,414
1,233
1,851
2,158
2,066
1,579
692
<40
41 - 49
50 - 59
60 - 69
70+
Physician Age

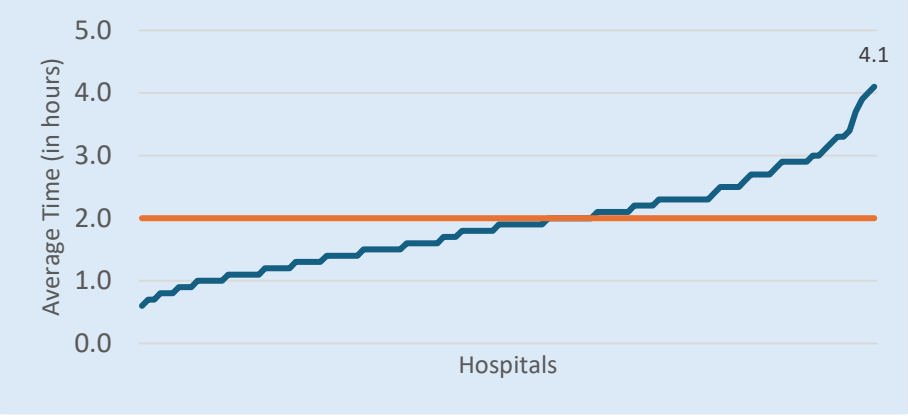
283. These findings are further confirmed by Premji K. et al. who report that between 2019-2025 nearly 15% (1.7 million) of Ontarians may lose their comprehensive family physicians, "as both patients and physicians age and fewer physicians practice comprehensiveness."[197]

284. Thus, the evidence of family physician shortages is compelling and clear and will only get worse if left unaddressed.

D. THE PHYSICIAN HUMAN RESOURCE CRISIS IN OTHER AREAS

285. The shortage of physicians is not only being felt in family medicine but in other areas as well. Emergency medicine ("EM") in particular is under strain. Emergency rooms are overcrowded. The average wait times to first assessment by a doctor is as high as 4 hours in some hospitals (see chart below), and, for some patients, the wait to see a physician in the last year was as high as 17 hours. This crisis has also manifested itself through temporary or permanent closures of 868 emergency departments and 316 urgent care centres.[198]

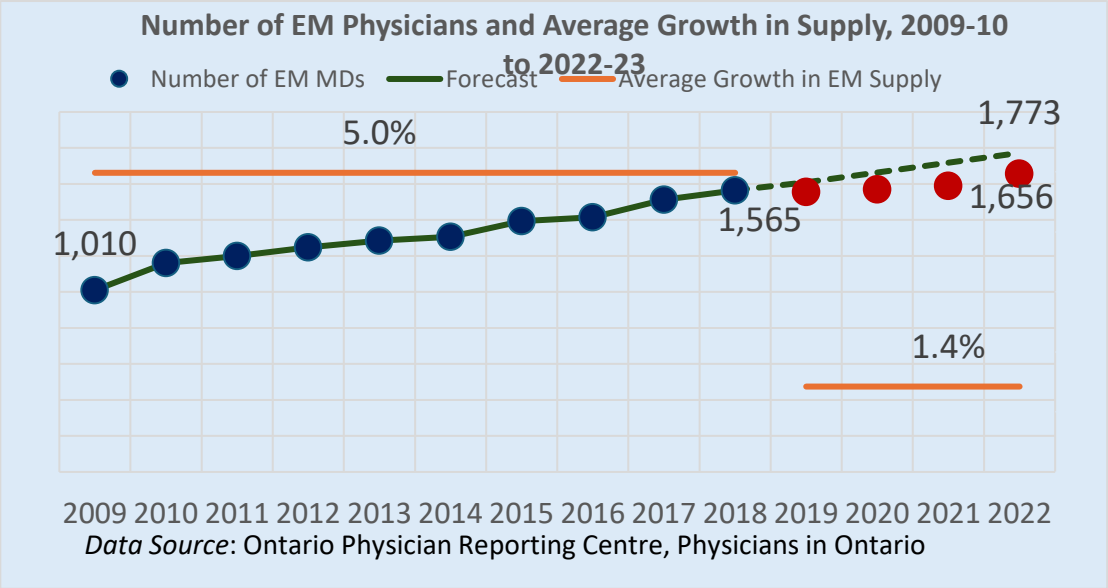
Average wait time to first assessment by a doctor in emergency departments



Source: Ontario Ministry of Health, Wait times in Ontario. https://www.ontario.ca/page/time-spent-emergency-department, assessed April 5, 2024. Each datapoint on the chart represents a hospital.

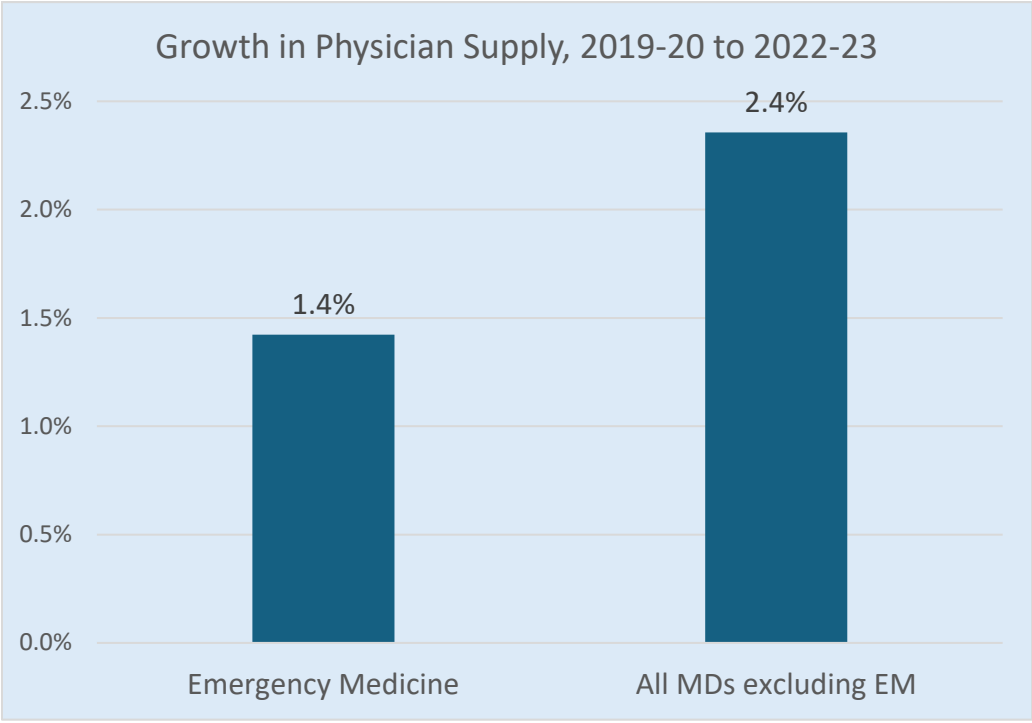
[197] Premji K. et al, *supra* at p. 1, TAB 12 BOD VOL 1.
[198] Ontario Health Coalition. Unprecedented and Worsening: Ontario's Local Hospital Closures 2023. (December 4, 2023), TAB 21 BOD VOL 1.

286. Between 2009-10 and 2018-19, the supply of EM physicians grew on average by 5.0% per year, and then declined in the pandemic and post-pandemic period to about 1.4% per year, as set out in the following chart:



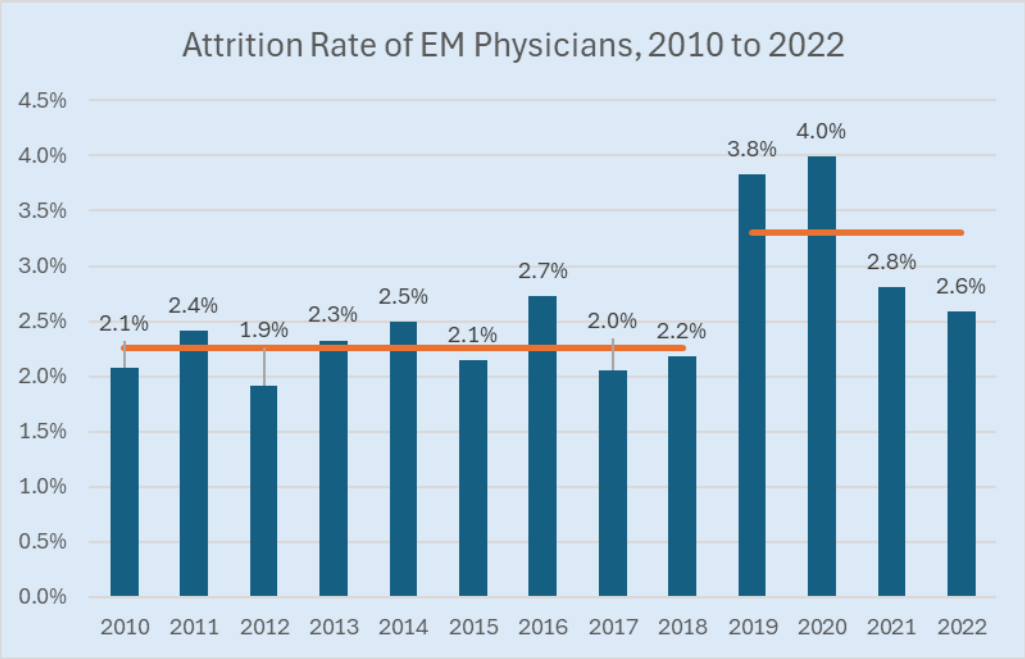
Data Source: Ontario Physician Reporting Centre, Physicians in Ontario

287. The growth in the supply of EM physicians in the post-pandemic period was lower than the average for all other specialties:



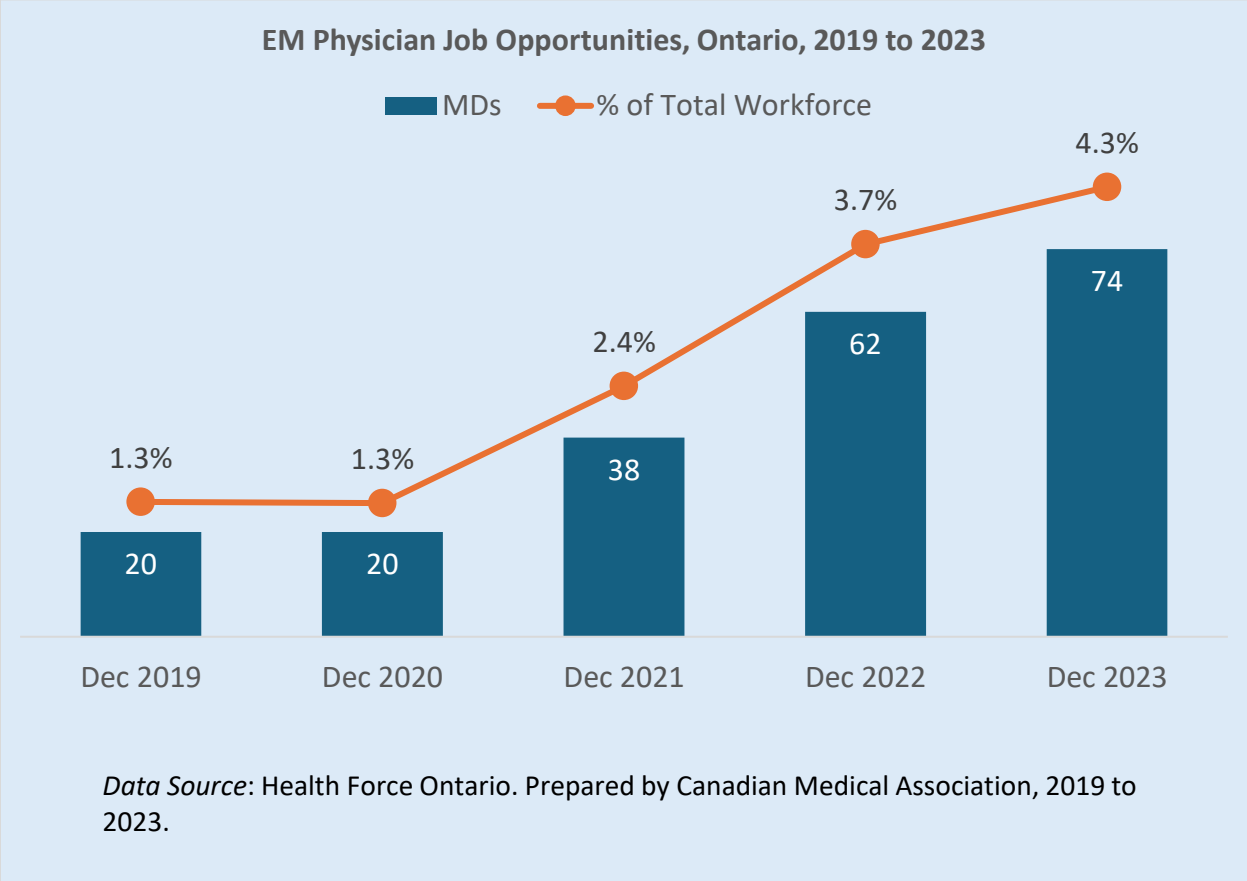
Data Source: Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2022) - Hamilton, ON: OPRC; 2024.

288. The attrition of EM physicians is also higher by about 1 percentage point (or by 46%, from 2.3% in the pre-pandemic period to about 3.3% in the post-pandemic period):



Data Source: Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2022) - Hamilton, ON.

289. The number of vacant positions advertised through the Health Force Ontario has also increased in the post-pandemic period, from about 1.3% of total workforce in December of 2019 (20 physicians) to about 4.3% in 2023 (74 physicians), excluding locums and part-time physicians, as reflected in the following chart:



Data Source: Health Force Ontario. Prepared by Canadian Medical Association, 2019 to 2023.

290. Further evidence of physician shortages can be seen in the unduly long wait-times to see a specialist in Ontario. While this is prevalent in all physician specialties, the data on wait times is available only for selected priority procedures. These waits have become uniformly longer in the post-pandemic era, increasing between 65 and 86 days for knee, hip, and cataract procedures between 2022 and 2019.[199]

291. This data on wait times provides further confirmation of the physician human resource crisis our health care system is currently facing.

292. There are however shortages in almost every specialty and every region of Ontario. These include shortages in the following areas:

[199] Data Source: Canadian Institute for Health Information (CIHI), Wait times for priority procedures in Canada. Published April 4, 2024.

- Northern, rural, and remote geographies;
- Inability across specialties and geographies to secure adequate, qualified locum coverage for necessary absences from practice;
- Psychiatry and mental health;
- Anesthesia;
- Cardiac surgery and paediatric cardiac surgery;
- Rheumatology;
- Obstetrics and gynecology;
- Small specialty retention challenges, e.g. radiation oncology; and
- Retention of academic clinical faculty to support sustainable medical education.

E. INCREASED COMPENSATION IS AN IMPORTANT PART OF THE SOLUTION

293. While not the sole solution, increased compensation plays an important role in addressing recruitment and retention problems. Thus, the OMA's compensation proposal is justified in part by the current physician human resources crisis. As well, as set out above, a portion of OMA's compensation proposal is needed to address the specific targeted proposals it has, many of which overlap with recruitment and retention issues in many areas.

294. This linkage is recognized in the arbitral case law. As recognized by the Chair of the Arbitration Board in the *OPSEU and Participating Hospital,* writing in the context of the hospital sector, "[r]ecruitment and retention issues are complicated, requiring a comprehensive and sophisticated approach, *but there is no question that compensation is a key driver in attracting and retaining ...employees*."[200]

[200] *Participating Hospitals v OPSEU, 2023 CanLII 75478 (ON LA),* ***supra***, TAB 13 BOA (emphasis added).

295. In *Crown in Right of Ontario v The Ontario Secondary School Teachers' Federation and The Elementary Teachers' Federation of Ontario*, Arbitrator Kaplan, as Chair of the Board of Arbitration, confirmed that compensation plays a key role in addressing recruitment and retention problems:[201]

> Increases to compensation are not a panacea because recruitment and retention issues are complicated and demand a curated and targeted approach. However, there is no question but that compensation is a driver in attracting employees to a field and retaining them once they are there.

296. In the specific context of physicians, research has also confirmed that decisions around early retirement and feelings of dissatisfaction with the profession are tied to compensation. For example, "compensation that has not kept pace with inflation" has been identified as a specific factor driving the shortage of family physicians by the OCFP.[202] Similarly, Flood et al. have confirmed that the shortage of family physicians is explained in part by the higher earning potential of other specialities.[203]

[201] ETFO and OSSTF, *supra,* TAB 2 BOA.
[202] OCFP Urgent Action, *supra,* TAB 101 BOD VOL 4.
[203] Flood CM, Thomas B, McGibbon E., "Canada's primary care crisis: Federal government response," *Healthcare Management Forum*, 2023;36(5):327-332 at 327, TAB 14 BOD VOL 1.

PART EIGHT - YEAR 1 COMPENSATION INCREASE PROPOSAL

A. THE OMA'S YEAR 1 PROPOSAL

297. The OMA is proposing a 22.9% increase for year 1 as follows:

(a) A 10.2% increase in respect of catch-up, based on the following factors:

(i) recognition and redress for the impact of inflation on the cost of living and the physicians' cost of practice;

(ii) recognition and redress for the increases received by other groups including those in the Ontario health and broader public sectors for the period during which compensation had been constrained after Bill 124; and

(iii) recognition and redress for the low price increases received by physicians since 2012 relative to the increases received by others in the Ontario health and broader public sector, and having regard to the increases to the costs of living and the cost of practice since 2012.

(b) A normative increase for year one of 12.7%, consisting of the following:

(i) 5% general price increase for 2024-25 (to be allocated to each section or physician grouping as the parties agree, or failing agreement, as this Board determines), and to be applied to the OHIP Schedule and flow-through to other elements of physician compensation under the Binding Arbitration Framework ("BAF"); and

(ii) 7.7% to provide for additional targeted funding for 2024-25, reflecting the imperative to invest in various targeted physician-related health care system initiatives.

298. These targeted physician-related health care system initiatives, which are reviewed in Part Nine below, include increased targeted funding to support compensation increases in such areas as:

(a) On-call funding for the new burden-based system;
(b) Targeted funding in response to the family medicine crisis;
(c) Targeted funding in response to the emergency medicine crisis;
(d) Targeted funding for APPs (including repair and modernization of existing APPs, funding for new APPs, as well as funding in response to the urgent need for specific repair for the CHAMO and Hospital for Sick Children APPs and for Academic Health Science Centre Phase 3 AFP funding);
(e) Targeted Funding to recognize the overall administrative burden facing physicians;
(f) Targeted Funding to address the longstanding erosion of reimbursement for technical fees;
(g) Targeted Funding to improve various aspects of physician human resources including improved funding for Locum Coverage, Underserviced Area Programs, Continuing Medical Education support and Skills optimization;
(h) Targeted Funding to support physician extenders including physician billing for delegated services;
(i) Targeted Funding to Redress the gender pay gap under the OHIP fee schedule;
(j) Targeted Funding for modernization of the OHIP Fee Schedule;
(k) Targeted Funding to recognize increased patient and service complexity;

(l) Targeted Funding for new services as a result of technological and other advances;

(m) Targeted Funding to support physician overhead;

(n) Targeted Funding to support physician retention;

(o) Targeted funding to support improvements to virtual care;

(p) Targeted funding for good faith payment for physician services and for improved manual review;

(q) Targeted Funding for benefits (pension, pregnancy and parental leave, and health benefits);

(r) Targeted funding for restructuring of CMPA support to reflect updated CMPA physician risk categories; and

(s) Targeted funding support for physician retirement savings.

299. The OMA's estimate of the value of the targeted funding proposed in these areas is set out immediately below:

PPC PROPOSALS	**$720.0**
Gender Pay Gap	$160.0
Technology	$160.0
Complexity	$160.0
Schedule Modernization	$240.0
CMPA	**$17.5**
FAMILY MEDICINE	**$744.1**
Unattached Fees	$110.0
After Hours Premium	$36.0
Family Health Group Premium	$41.0
Comprehensive Care Cap	$356.5
Negation	$105.6
Quality Improvement	$50.0
RNPGA (rural and northern)	$15.0
Community Health Centre	$30.0
VIRTUAL CARE	**$99.1**
100% Reimbursement for Phone	$44.7
Consultations by Phone	$51.3
Comprehensive Team Fee	$2.9

Case Conferencing	$0.2
OVERHEAD FEE	**$60.0**
ADMIN BURDEN	**$947.8**
Administration Fee	$812.8
MedsCheck	$135.0
HHR	**$409.2**
CMPA Subsidy Late Career	$2.2
Travel and Rurality Premiums	$7.0
Subsidy for Locum Contracts	$96.8
Underserviced Area Programs	$10.0
Continuing Medical Education	$103.1
Skill Optimization	$10.0
Retention	$180.1
EMERG MED	**$391.0**
Base Payment	$244.0
Hours Coverage	$128.0
Uninsured	$19.0
TECH FEES	**$473.6**
ALTERNATIVE PAYMENT PLANS	**$506.1**
Repair and Modernization	$40.0
New Agreements/Expansion	$140.0
Oncology	$15.0
CHAMO and Sick Children	$176.4
Academic Health Sciences	$131.7
Divested Provincial Psychiatric	$3.0
ON CALL FUNDING	**$110.0**
GOOD FAITH	**$3.8**
PHYSICIAN EXTENDERS	**$103.9**
Delegation Billing	$93.9
Physician Extenders in EDs	$10.0
RETIREMENT	**$300.2**
BENEFITS	**$40.5**
Physician Health Program	$17.0
TOTAL TARGETED	**$4,926.8**

300. The OMA recognizes that the total overall value of the various targeted increases and investments the OMA proposes over the full four years of the 2024-28 PSA is significant – approximately 30% of the existing expenditure on physician services.

301. However, the need for this targeted funding reflects the persistent and chronic failure to address the growing need for enhanced funding support and investment in these and other targeted areas, given the failure to address these needs since 2012.

302. The 7.3% amount for targeted compensation increases sought by the OMA in Year 1 is approximately ¼ of this total. In this respect, the structure of the OMA proposal generally reflects the parties' agreement under the "Year 3/Year 1 Implementation and Procedural Agreement" that 30% of the overall increase in Year 1 would be committed to targeted physician compensation increases. It is anticipated that, with the awarding of the Year 1 targeted funding sought, some of the proposed improvements can begin to be implemented immediately, assuming, of course, that the government is prepared to co-operate in these much-needed endeavours.

B. THE OMA'S CATCH-UP CLAIM

I. Inflation

303. The OMA acknowledges that the amount received under the 2021-2024 PSA was the result of a freely negotiated and ratified agreement. However, since that agreement was reached, there have been significant changes in the entire negotiations landscape in Ontario and elsewhere including the striking down of Bill 124, which was the single most important basis for the agreement reached by the OMA, not to mention the growing impact of inflation on both the physicians' cost of living and cost of practice. Subsequent awards and agreements have addressed these singularly important developments as is detailed below. While the OMA does not have a "reopener" in its PSA, it now does have the opportunity and, indeed, the necessity to seek to obtain redress and catchup not only for what has occurred in the past 3 years but, also, what has occurred and how physicians have been adversely impacted—and the consequence of that impact on the health care system-- since 2021 and earlier.

304. The OMA submits that its claim for catch-up is justified and necessary in light of the recent high rates of inflation and the resulting need to address the erosion of physician compensation, the impact of which is further compounded by increases to overhead and the costs of practice due to inflation.

305. The OMA's proposal is also consistent with replication, comparability, and the principle of "catch up". The concept of catch up is well recognized in the arbitral jurisprudence. As explained by Arbitrator Gedalof in *UTFA v. University of Toronto,* "catch up" is essential to the legitimacy of the interest arbitration process. Historical benchmark comparisons become artificial if the need for catch up is not accounted for...[W]here the parties have long-since adopted the usual replication model for interest arbitration, the availability of catch up in appropriate circumstances is...fundamental to the comparative exercise and ought to be non-controversial.[204]

306. Applying the concept of catch-up, Arbitrator Gedalof awarded an 8% across the board increase for 2022 (in addition to the 2% that had earlier been agreed for the first two years of the Bill 124 moderation period restrictions), in order to make up for losses in relation to CPI and to other comparators experienced over the previous two years.

307. Furthermore, as explained by the Chair of the Board in the Ontario Power Generation award:[205]

> Inflation is not, as hoped, transitory. The advent of significant and sustained inflation constitutes a material change. Inflation is entrenched and even if it now begins to abate, inflationary increases are baked in and have significantly affected real wages of employees in the two years of the term...
>
> Inflation...is compelling, as was recognized by OPG in the PWU-MOS. Inflation is not now a "non-issue." Accounting for inflation is now firmly a part of the interest arbitration matrix. Recent electricity sector awards – along with increasing numbers of awards across the system – not just the PWU-MOS – make this clear.

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[204] *University of Toronto v University of Toronto Faculty Association*, 2023 CanLII 85410 (ON LA) at para. 93, TAB 14 BOA.
[205] *OPG v The Society*, *supra*, TAB 7 BOA.

308. A similar approach vis-à-vis inflation was adopted in the *OPSEU and Participating Hospitals* award, whereby the Chair similarly explained:

> Replicating free collective bargaining – what these parties would have likely done had they been able to strike or lockout – is the most important of the normative interest arbitration criteria...
>
> Inflation was 6.8% in 2022 and no one is seriously suggesting it will dip below 3% in 2023. If all goes well – and some of the economic projections turn out to be correct – it may begin to reach historical numbers by 2024, or it may not. We need to address this in our award. Inflation – before and during the term of this agreement – has been persistent and its results are now entrenched.
>
> Even if inflation begins to fall, the increases to the cost of living – and therefore the real erosion of spending power – will not change: they are now baked into prices. No one suggests that de-inflation is on the horizon.[206]

309. The OMA submits that this Board should adopt a similar approach by awarding catch-up for losses due to inflation (in addition to fair and reasonable increases for 2024, to be discussed further in Part Eight, Section C below).

310. There can be no doubt that inflation in the last three years has been extraordinary. At the same time as Ontario's economy rebounded rapidly from the pandemic with exceptional GDP gains in 2021 and 2022[207] and the Ontario government saw large budget surpluses,[208] the 2021-24 period was also marked by the highest inflation rates been in the past forty years. For physicians, unlike for employees, inflation has also had a doubly negative impact as it has both eroded the value of any PSA compensation rate increases they have received and, at the same time, significantly increased their costs to practice as overhead expenses have gone up.

311. The period of high inflation began in the spring-summer of 2021, peaking in 2022 when the Consumer Price Index ("CPI") for Ontario rose 6.8%, a 40-year high. Inflation

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[206] *Participating Hospitals v OPSEU*, *supra,* TAB 13 BOA.
[207] FAO Spring 2023 Outlook, *supra,* at pp 1-2, TAB 79 BOD VOL 3; FAO Winter 2024 Outlook, *supra,* TAB 80 BOD VOL 3.
[208] FAO Spring 2023 Outlook, supra at pp. 2-4.

remained persistently high in 2023 at 3.9%,[209] despite the higher interest rate policies introduced by the Bank of Canada.

312. Considering inflation on a retrospective basis as found to be appropriate by Arbitrator Gedalof,[210] over the course of the 2021-2024 PSA, inflation in Ontario totaled approximately 15.1% (compounded). In contrast, over the same time period physician fee rates increased by only 4.9% (compounded). In other words, heading into the first year of the 2024-2028 PSA, physician fees have been eroded by approximately 10.2% as against inflation, over the course of the previous 2021-24 PSA.

313. By comparing the physician fee increases to inflation over time, the extent of the erosion of compensation due to inflation is apparent. As reflected in the following chart, historically prior to 2000, physician fee increases were consistently lower than inflation.[211] However, between 2000 and 2012, physician fee increases largely caught up to the prior losses against inflation. As a result of the fee reductions followed by the unilateral cuts in 2012-2017 period, physician fee increases again seriously eroded as against inflation, resulting in a gap of over 24% by 2016-17.

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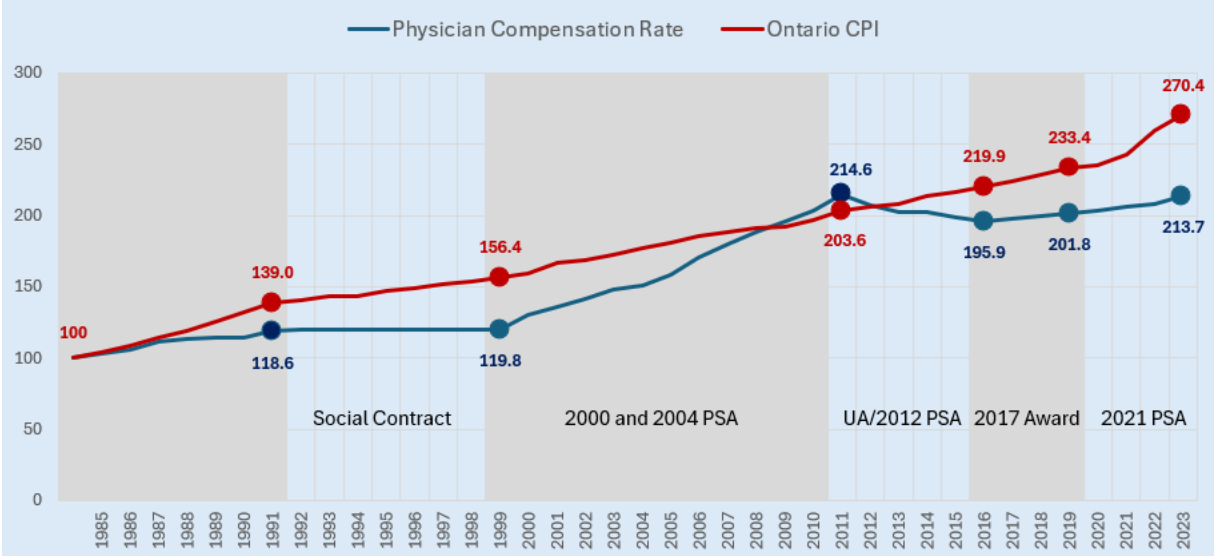
[209] Data Source: Statistics Canada, *Consumer Price Index, monthly, not seasonally adjusted*, (Table: 18-10-0004-01), TAB 104 BOD VOL 4.

[210] *University of Toronto v University of Toronto Faculty Association*, 2023 CanLII 85410 (ON LA) [“*University of Toronto*”] at para. 89, TAB 14 BOA.

[211] The compensation rate increases prior to 2000 are described earlier in this brief. The compensation rate increases from the 2000, 2004, 2008, 2012, and 2021 Agreement are based on a detailed costing that includes payment changes to all items, including fees, apps, and programs. The 2017 compensation rate increase is based on the Kaplan Award. The unilateral cuts in 2012 and 2015 are based on a detailed cost of all affected items. The across the board cut in 2015 is not included in these numbers, as these cuts were reversed in the 2017 Award.

Physician Price Increases and Consumer Price Index, 1985 to 2023, Ontario



Sources: Statistics Canada. Table 18-10-0004-01 Consumer Price Index, monthly, not seasonally adjusted; Schedule of Benefits, Physician Services Agreements and Unilateral Actions (OMA Calculations).

314. This eroding price rate relative to inflation is also seen in in the table below. Since 2012, increases to the rate of physician fees have significantly trailed inflation, which cumulatively has had a significant impact on physician compensation. While inflation was 32.8% over the 2012-23 period, the overall level of physician fees increases/decreases (including the reductions caused by the targeted cuts prior to 2017) over that same period is zero, and only 8.8% even excluding the targeted cuts. The OMA submits that its catch-up proposal will at least go some way to restoring the historic pattern of fee increases matching inflation from pre-2012:

Year	OMA Physician Fee Increases April 1*	Average Annual Inflation Ontario
2012	-3.80%	1.4%
2013	-1.40%	1.0%
2014	-0.80%	2.4%
2015	-1.00%	1.2%
2016	-1.80%	1.8%
2017	0.75%	1.7%

2018	1.25%	2.4%
2019	1.00%	1.9%
2020	1.00%	0.7%
2021	1.00%	3.3%
2022	1.00%	6.9%
2023	2.80%	4.2%

**does not include the 3.5% unilateral cut in 2016 that was returned in 2019*

315. When one looks forward to the first year of the 2024-2028 PSA, inflation is expected to be between 2.5-3%. Thus, looking just at inflation since 2021, a Year 1 increase of approximately 13% is needed just to ensure that increases to the level of physician fees is not eroded due to inflation since the start of the 2021-24 PSA.

316. Moreover, as noted above, the impact of inflation on physicians since 2011 is further compounded by the fact that inflation results in increases to physician costs of practice. As a result, the net real physician compensation rate has deteriorated even more than is captured just by comparing the differences between inflation and physician price increases. Thus, the actual impact of inflation on physician expenses of practice, and in particular the compounding effect of increasing costs of practice on a given level of physician compensation, must be taken into account when determining appropriate price increases.

317. Accordingly, this Board should award the OMA catch-up compensation rate increases that reflect inflationary increases at least since 2021. The OMA's proposal does exactly that – i.e. an extra 10.2% effective April 1, 2024 for the losses against inflation during the 2021-24 PSA, together with an additional 5% general increase for 2024-25 (which for the first time in some time would provide the OMA with modest real price increases relative to inflation). The OMA proposal takes into consideration the price increases already received in the 3 years of the 2021-2024 PSA. In contrast, the MOH's proposal of just 3% in the first year of the agreement will effectively lock in place the price reduction for physician services as against inflation since 2021, and earlier.

II. Comparisons to Broader Public Sector Increases

318. As noted, replication is the central guiding principle for interest arbitration and requires consideration of comparators. Because of the impact of Bill 124 on the 2021-24 PSA, as well as the prior sub-normative fee increases for physicians in the period 2012 to 2020, the OMA submits that the OMA's claim for catch-up must include an examination of key relevant settlements and interest arbitration awards over various time periods, including 2012-2023 (a time period that includes fee freezes together with various unilateral cuts to physician fees that remain in effect), 2017-2023 (the period since the BAF commenced), and 2021-2023 (the period covering the last PSA which was seriously constrained by the presence of Bill 124.

a) Hospital Sector Increases

319. When compared to the normative increases paid to the hospital sector employees, it is apparent that physician fees have failed to keep up with the normative increases provided to all other hospital groups and that a significant degree of catch up is warranted.

320. As set out in the table below, and not even accounting for additional targeted salary and compensation increases received by hospital sector employees since 2021, OMA physician fee increases have significantly trailed hospital comparator increases since 2012, a gap which has only grown over time. Notably, and not accounting for the additional increases to salaries and compensation in the hospital sector as a result of further targeted salary grid adjustments and other compensation increases (e.g. for benefits and premiums), the following chart sets out the annual compensation rate increases (and, in the case of physicians, fee decreases), from 2012 to 2023, as well as the cumulative comparative compensation rate changes.

Annual Compensation Rate Changes

Year	OMA** April 1	PARO July 1	ONA April 1	OPSEU April 1	CUPE Sept 29
2012	-3.80%	0.00%	0.00%	0.00%	2.00%
2013	-1.40%	1.40%	2.75%	2.75%	0.7%
2014	-0.80%	1.40%	1.40%	1.40%	0.7%
2015	-1.00%	1.40%	1.40%	1.40%	0.7%

2016	-1.80%	1.40%	1.40%	1.40%	0.7%
2017	0.75%	1.40%	1.40%	1.40%	1.40%
2018	1.25%	1.40%	1.40%	1.40%	1.40%
2019	1.00%	1.40%	1.75%	1.75%	1.60%
2020	1.00%	1.75%	1.75%	1.75%	1.65%
2021	1.00%	3.00%	2.00%	1.75%	4.75%
2022	1.00%	4.75%	3.00%	4.75%	3.50%
2023	2.80%	TBD	3.50%	3.50%	3.00%

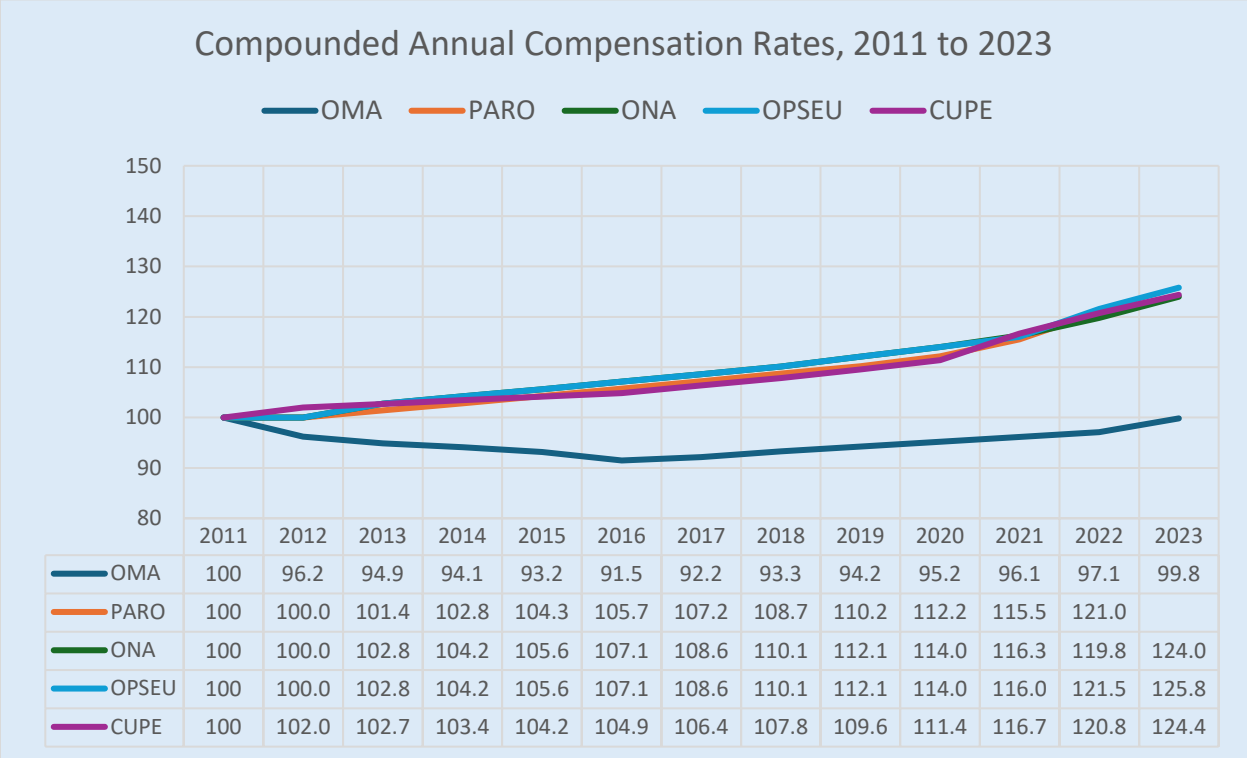
Cumulative Compensation Rate Changes

Time Period	OMA	PARO	ONA	OPSEU	CUPE
2012 – 2023*	-0.2%	21.0%	24.0%	25.8%	24.4%
2017 – 2020*	4.1%	6.1%	6.4%	6.4%	6.2%
2021 – 2023*	4.9%	7.9%	8.7%	10.3%	11.7%

* PARO 2011-2022, 2017-2022, and 2021-2022

** OMA numbers do not include the 3.5% unliteral across the board cut (3.95% fee for service and 2.65%non-fee for service) in 2015 that was reinstated in 2019 by the Kaplan arbitration award

321. As the following graph reveals (and not even accounting for additional targeted increases received by these groups), since 2012, OMA physician fee increases have trailed other key hospital comparator increases by anywhere between 21 to 26%.



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
OMA	100	96.2	94.9	94.1	93.2	91.5	92.2	93.3	94.2	95.2	96.1	97.1	99.8
PARO	100	100.0	101.4	102.8	104.3	105.7	107.2	108.7	110.2	112.2	115.5	121.0	
ONA	100	100.0	102.8	104.2	105.6	107.1	108.6	110.1	112.1	114.0	116.3	119.8	124.0
OPSEU	100	100.0	102.8	104.2	105.6	107.1	108.6	110.1	112.1	114.0	116.0	121.5	125.8
CUPE	100	102.0	102.7	103.4	104.2	104.9	106.4	107.8	109.6	111.4	116.7	120.8	124.4

* Does not include any PARO increases for 2023

** OMA numbers include targeted fee cuts of approximately 8.8% from 2012 to 2015 still in effect, but do not include the 3.5% unilateral across the board cut (3.95% fee for service and 2.65%non-fee for service) in 2015 that was reinstated in 2019 by the Kaplan arbitration award

322. Looking over the shorter term (and not accounting for the actual percentage increases received by hospital employees, which will be reviewed immediately below), whether one measures since 2017 or since 2021, OMA physician fee increases have significantly trailed other comparator ATB increases. As is evident, while over the period 2017-21, the OMA only received 4%, others received between 6.1% and 6.4%; for the period 2021 to 2023, the OMA trails increases received by others (not including PARO which has not yet negotiated the 2023 increase) by between 3.7% (ONA) and 6.45% (CUPE).

Annual Compensation Rate Changes

Year	OMA** April 1	PARO* July 1	ONA April 1	OPSEU April 1	CUPE Sept 29
2017	0.75%	1.40%	1.40%	1.40%	1.40%
2018	1.25%	1.40%	1.40%	1.40%	1.40%
2019	1.00%	1.40%	1.75%	1.75%	1.60%
2020	1.00%	1.75%	1.75%	1.75%	1.65%
2021	1.00%	3.00%	2.00%	1.75%	4.75%
2022	1.00%	4.75%	3.00%	4.75%	3.50%
2023	2.80%	TBD	3.50%	3.50%	3.00%

Cumulative Compensation Rate Changes

Time Period	OMA**	PARO*	ONA	OPSEU	CUPE
2017 – 2021	4.1%	6.1%	6.4%	6.4%	6.2%
2021 – 2023*	4.8%	7.75%	8.5%	10%	11.25%

323. However, as noted, these calculations significantly understate the actual differences in terms of increases provided to physicians and other health sector groups, since these other groups also received a variety of other compensation increases, including grid adjustments. For example, in the 2021-2024 period, *actual* ONA increases when grid adjustments are taken in consideration were, on average, 14%, while the OMA increases were 4.8%. The recent awards and/or settlements for these other health sector groups are discussed below.

i) ONA

324. Over the period 2021 to 2024, ONA has received ATB increases of 2% for April 1, 2021 (the Stout reopener award),[212] 3% for April 1, 2022 (the Gedalof reopener award),[213] and 3.5% for April 1, 2023 (the Kaplan award).[214] However, this 8.5% increase over the

[212] Ontario Hospital Association v Ontario Nurses' Association, 2023 CanLII 29345 (ON LA) ["Stout Reopener"] at para. 27, TAB 15 BOA.
[213] Participating Hospitals v Ontario Nurses Association, 2023 CanLII 33967 (ON LA) [Gedalof Reopener], TAB 16 BOA.
[214] *The Participating Hospitals (Represented by the Ontario Hospital Association) v ONA*, 2023 CanLII 65431 (ON LA), TAB 17 BOA.

three years significantly understates the actual percentage compensation increases awarded, since, in both the Gedalof and Kaplan awards, significant improvements were made to the ONA wage grid.

325. For his part, Arbitrator Gedalof collapsed the nurses' grid between eight and twenty-five years, resulting in an additional 1.8% for all RNs between the eight- and twenty-five-year steps. This works out to approximately 0.9% increase for the bargaining unit as a whole. As a result, the Gedalof increase for 2022 is appropriately characterized as a 3.9% total increase for nurses in 2022.

326. The Kaplan award contained even more substantial changes to the ONA wage grid (valued at approximately 4.75% overall), which when combined with the 3.5% across the board increase, amounts to an 8.25% total increase to overall salary rates in 2023 alone.[215]

327. As a result, the actual value of the total wage increases for ONA for the period April 1, 2021, to March 31, 2024 is 15.15%. Over this same period, compensation rate increases for physicians was only 4.8%.

328. Moreover, given the additional 3% awarded by Arbitrator Kaplan for ONA effective April 1, 2024, the total received by ONA over the four years 2021 to 2025 is 18.15%, while to this point physicians have received only 4.8%.[216]

ii) CUPE-SEIU

329. Another reopener award for the Health Care Sector, *CUPE-SEIU and Participating Hospitals,* provides for wage increases of 4.75% and 3.5% for 2022 and 2023 (4.75% effective January 1, 2022 for SEIU with 3.5% effective January 1, 2023, and 4.75% for CUPE effective September 29, 2021 with 3.5% effective September 29, 2022).

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[215] ONA, "Frequently Asked Questions – and Answers For Ontario Nurses' Association (ONA) Hospital Members" (August 2023), TAB 105 BOD VOL 4.
[216] *Ibid.* TAB 105 BOD VOL 4.

330. However, the CUPE-SEIU award also includes significant other compensation increases for members such as a $2.00 an hour increase that was added to the RPN wage grid along with increases to call back and shift and weekend premiums and massage and vision benefits,[217] all of which results in a total increase over these two years alone of approximately 11%.

331. Most recently, on April 16, the arbitration award for *CUPE and Participating Hospitals* was released covering what would have been the third year of the Bill 124 moderation period.[218] This award provides for a further 3% across-the-board increases as of both September 29, 2023 and September 30, 2024, respectively, together with additional improvements to benefits and premiums which the OMA estimates amount to an extra 0.5% in compensation. This means that over the three-year Bill 124 moderation period, while OMA fee increases were 4.8%, CUPE (together with SEIU and UNIFOR), received total increases of over 14%.

iii) OPSEU

332. In *OPSEU and Participating Hospitals* reopener award, the Board of Arbitration chaired by Arbitrator Kaplan awarded the following across-the-board increases inclusive of the 1% initially awarded, averaging 3.75% a year:

- April 1, 2022: 4.75%
- April 1, 2023: 3.5%
- April 1, 2024: 3.0%

333. In the Arbitrator Kaplan's view, these across-the-board increases were needed and justified by persistent and entrenched inflation which has resulted in a "real erosion of spending power."[219]

334. Notably, in addition to these wage increases, the OPSEU hospital reopener award also included an additional wage grid adjustment for registered technologists and above

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[217] *CUPE/OCHU and SEIU,* ***supra***, TAB 6 BOA.
[218] *The Participating Hospitals v OCHU/CUPE,* 2024 CanLII 33105 (ON LA), TAB 18 BOA.
[219] ***Participating Hospitals v. OPSEU, supra,*** TAB 13 BOA.

of 1.75% to address recruitment and retention issues, along with a one-time $1,750 lump sum pandemic pay amount, increases to call-back, shift and weekend premiums, vision and a $500 health care spending account amount. Thus, the actual compensation provided to OPSEU health professionals was more than just the across-the-board increases reflected in the tables and charts above. As well, with the OPSEU pandemic pay award (and the PARO award discussed below), doctors are now effectively the sole frontline health care providers who did not receive any form of pandemic pay.

iv) PARO

335. In *Ontario Teaching Hospitals v. PARO*, Arbitrator Kaplan, acting as sole arbitrator, awarded the following increases for July 1, 2021 and July 1, 2022:[220]

July 1, 2021: 3% (inclusive of the 1% Bill 124 amount)

July 1, 2022: 4.75% (inclusive of the 1% Bill 124 amount)

336. However, as for other hospital sector employees, the PARO award included significant additional compensation increases above the ATBs, including:

- Flat rate increases to the PGY1 classification step of a further $740, to PGY7 by a further $990, and to PGY8 by a further $1,555
- Increases to the in-hospital weekday and conversion weekday call stipend, the in-hospital weekend and conversion weekend call stipend, the home weekday and qualifying weekday call stipend, and the home weekend and qualifying weekend call stipends
- Other benefit improvements

337. Cumulatively, these additional increases amounted to a further 1.5%, bringing the PARO compensation increase for 2021 and 2022 alone to 9.25%. PARO is currently

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[220] *Ontario Teaching Hospitals (OTH) v Professional Association of Residents of Ontario (PARO),* 2023 CanLII 83841 (ON LA), TAB 19 BOA.

bargaining for the period commencing July 1, 2023. By contrast, over 2021 and 2022, OMA physician fee increases were only 2%.

338. In an earlier award, Arbitrator Kaplan also awarded the residents pandemic pay, noting that "Residents were intimately and integrally on the frontlines" during the pandemic.[221] The same of course can also be said of doctors who, as already noted, remain alone among front-line health providers in having received no additional pandemic pay-related recognition for their heroic and significant pandemic efforts. Instead, over the 2021-24 period, physicians to this point have received compensation increases that failed to even keep up with inflation, and that were sub-normative compared to the increases received by others.

339. Factoring in the actual value of the compensation rate increases received by ONA, CUPE, PARO and OPSEU, the contrast with physicians is stark, and provides ample justification for the OMA's catch-up proposal.

340. Indeed, when physician fee increases (and unilaterally imposed decreases) for the period 2012 to 2023 are compared to the normative increases paid to comparators in the hospital sector, it is clear that physician increases have fallen significantly further behind than the 10.2% catch-up proposed by the OMA. In these circumstances, catch-up of more than the 10.2% the OMA proposes would be warranted based only on consideration of comparators during the period from 2012 to 2021; however, when the period 2021-24 is also factored in, the OMA proposal actually appears modest and is certainly reasonable and justifiable having regard both to inflation over that time period, increased practice costs and the actual percentage value of the increases received by ONA and others in the hospital sector.

b) Justice Sector Increases

341. The OMA submits that compensation trend in increases in the justice sector provides another, although somewhat less compelling comparator. The justice sector also

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[221] *Ontario's Teaching Hospitals (Acting as successor to CAHO) v Professional Association of Residents of Ontario*, 2021 CanLII 50762 (ON LA), TAB 20 BOA.

includes highly skilled and educated professionals paid from the public purse. A review of the increases paid to this group from 2021 reveals that the physician fees increases have been much smaller than the increases paid to judges and related judicial officers. Once again, the OMA submits that catch up is required.

342. During the recent period, the salary increases for Judges of the Ontario Court of Justice have been as follows:

YEAR	Provincial Judges Salary	Percentage Increase
April 1 2019	$310,337.00	3.23%
April 1 2020	$320,742.00	3.35%
April 1 2021	$344,020.00	7.26%
April 1 2022	$350,212.00 (plus any Commission Increase not yet determined)	1.80%
April 1 2023	$360,369.00 (plus any Commission Increase not yet determined)	2.90%
April 1 2024	IAI (plus any Commission Increase not yet determined)	

343. Thus, for the period April 1, 2021 to March 31, 2024, the three years that overlap with the previous PSA, judges have received increases totalling approximately 12%. In addition, the judges' salaries for 2022 and 2023 is yet to be finalized as they are subject to determination by the Provincial Judges Remuneration Commission. As a result, judicial salary increases may indeed be more than what is set out above. By contrast, fee increases for physicians over the 2021 to 2024 period were only 4.8%.

344. Justices of the Peace ("JPs") are another judicial comparator. As set out below, JPs have seen even greater in across-the-board increases during the relevant time period than provincial judges:[222]

YEAR	Justice of the Peace Salary	Percentage Increase
April 1 2019	$141, 282.00	3.76%
April 1 2020	$148,961.76	5.43%
April 1 2021	$157,163.58	5.51%
April 1 2022	$172,010.00	9.45%
April 1 2023	TBD by Commission Process	
April 1 2024	TBD by Commission Process	

345. For the period April 1, 2021 to March 31, 2022, the relevant years at issue here, JPs have received increases totalling approximately 14.96%, even before their yet to be decided increase for April 1, 2023 is added in. Physician increases trail JP increases by over 10% heading over the course of the last PSA, a gap that will undoubtedly increase once the 2023 JP increase is determined.

346. Another justice sector comparator is Associate Judges in Ontario. Associate Judges, formerly called Masters, are provincially appointed judicial officers who have the authority to hear and determine certain matters in civil cases, including motions, pre-trials and case conferences. Their salaries and salary increases during the relevant period are as follows:

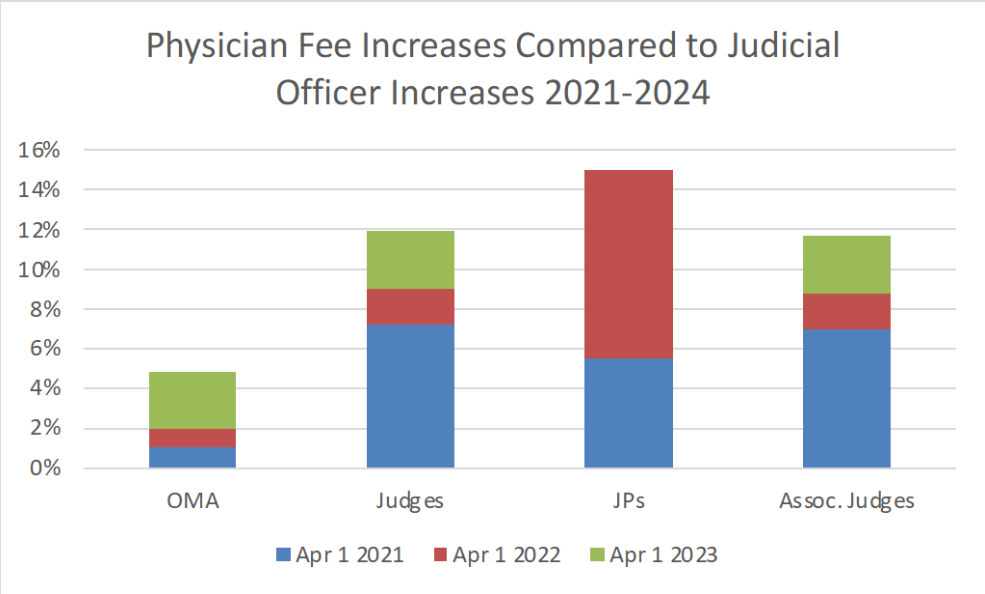
YEAR	Associate Judge Salary	Percentage Increase
April 1 2019	$264,833.00	
April 1 2020	$273,308.00	3.2%
April 1 2021	$292,440.00	7.00%
April 1 2022	$297,704.00	1.80%
April 1 2023	$306,337.00	2.90%

[222] O. Reg. 247/94: *Salaries and Benefits of Justices of the Peace* under *Justices of the Peace Act*, R.S.O. 1990, c. J.4, TAB 106 BOD VOL 4.

April 1 2024	TBD by Commission Process	

347. Their 2021-2024 salary increases totaled 11.7%, once again significantly in excess of the 4.8 received by doctors in the comparable period.

348. The following chart summarizes the disparity between physician fee increases and those paid to judicial officers since 2021 (not including yet to be determined further Commission increases).



c) Ontario Public Service

349. The OMA submits that the Ontario Public Service ("OPS"), while not a highly relevant comparator for physician compensation, has received increases over the relevant periods in excess of the increases paid to physicians.

350. The following table sets out increases paid to the two largest OPS groups, OPSEU Central and AMAPCEO, from 2012 to present, compared to the OMA:

YEAR	OMA*	OPSEU	AMAPCEO
2012	-3.80%	2%	0%
2013	-1.40%	0%	0%

2014	-0.80%	0%	0%
2015	-1.00%	0%	0%
2016	-1.80%	0% (plus a 1.4% lump sum)	1.4%
2017	0.75%	1.4% 1.5%	1.4% 1.5%
2018	1.25%	0%	0%
2019	1.00%	1.0% 1.0%	1.0% 1.0%
2020	1.00%	1.0% 1.0%	1.0% 1.0%
2021	1.00%	1.0% 1.0%	1.0% 1.0%
2022	1.00%	3.0%	3.0%
2023	2.80%	3.5%	3.5%
2024	TBD	3.0%	3.0%
Cumulative Uncompounded Increases 2012-2023	0%	17.30%	16.80%
Cumulative Uncompounded Increases over moderation period	4.80%	9.50%	9.50%

351. Thus, the OPS numbers do further illustrate how out of line physician increases are with all other groups.

352. As well, the recent reopener awards for these groups include some additional compensation adjustments not reflected in the ATBs. Both the Ontario Public Service Employees Union ("OPSEU") Unified[223] award and the Association of Management, Administrative and Professional Crown Employees of Ontario ("AMAPCEO")[224] awards are consent awards that arise in the context of Bill 124 reopeners. As noted, these awards provide for increases of 3% in 2022, 3.5% in 2023, and 3% in 2024, inclusive of the 1% already provided in those years.

353. The OPSEU Consent Award also includes wage adjustments for certain classifications in addition to the ATBs. The scale and size of these increases only become apparent when the wage grids in the current collective agreement[225] are compared to those in the Consent Award. In some cases, these additional increases were over 20% (see for example the 21.2% increase for the Ambulance Communications Officer 1 and the 9.79 % increase for Resource Technician 2 (G29 Salary Note).

354. As well, OPSEU has agreed to a new dispute resolution process to address wage disparities in other job classifications,[226] which is not found in the Consent Award but set out in a side agreement.[227] Pursuant to this process and agreement, other classifications will be reviewed and may receive further compensation increases where there are compensation-related recruitment and retention issues. In other words, the OPSEU Consent Award is not the complete agreement between the parties with respect to compensation, since there is a binding dispute resolution process applicable to an unknown number of OPSEU classifications and employees who may be receiving further compensation increases.

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[223] *Ontario (Treasury Board Secretariat) v OPSEU*, (Lee) (unpublished consent award) (2024), TAB 21 BOA.
[224] *Ontario (Treasury Board Secretariat) v AMAPCEO*, (Lee) (unpublished consent award) (2024), TAB 22 BOA.
[225] OPSEU Unified Collective Agreement, Expiry December 31, 2024, Unified Salary Schedule at pp. 335, 402, TAB 107 BOD VOL 4.
[226] OPSEU News Release, "Over 30,000 OPS Unified Members Win Largest Wage Increases since 2012!", January 22, 2024, TAB 108 BOD VOL 5; *MOS between Crown and OPSEU,* January 21, 2024, TAB 108 BOD VOL 5.
[227] *MOS between Crown and OPSEU*, January 21, 2024, TAB 109 BOD VOL 5.

355. In addition, the OPSEU Corrections Award, [228] which has a term of January 1, 2022 to December 31, 2024, provides for increases of 3% in 2022, 3.5% in 2023, and 3% in 2024, but also contains a further 1% special adjustment in 2022 for Correctional Officers, Youth Workers, Probation Officers/Probation and Parole Officers (i.e. the vast majority of the bargaining unit), as well as even larger increases and a new wage grid for nurses.

d) Other Broader Public Sector and Public Service Settlements and Awards

356. The pattern of ATB increases seen in the health sector is in part the result of arbitrators replicating the clear pattern that emerged in 2023 from a number of other broader public sector settlements affecting tens of thousands of workers in the province.

357. These key agreements include the Power Worker's Union ("PWU") settlement reached with Ontario Power Generation ("OPG") in March of 2023, which was approved by Treasury Board itself, and which provided for the following significant wage increases in 2022 and 2023:[229]

- April 1, 2022: 4.75%
- April 1, 2023: 3.5%
  Lump Sum: Date of Ratification, lump sum payment of $2500 to all active Regular and Term Employees. A further lump sum payment of $2500 on April 1, 2023

358. Shortly thereafter, Arbitrator Kaplan awarded the following additional compensation increases to the Society of Professional Engineers (the "Society") employed at OPG on a reopener: [230]

- January 1, 2022: 3% (4% total)
- January 1, 2023: 2.25% (3.25% total)

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[228] *Ontario (Treasury Board Secretariat) v OPSEU*, 2023 CanLII 114519 (ON LA) (Kaplan), TAB 23 BOA.
[229] Power Workers Union, "OPG Memorandum of Settlement - Summary" (March 10, 2023), TAB 110 BOD VOL 5; See also Robert Benzie, "Ontario power workers get retroactive raises in 2-year contract deal" *Toronto Star* (May 3, 2023), TAB 111 BOD VOL 5.
[230] *OPG v The Society*, *supra*, TAB 7 BOA.

359. Notably, following the reopener award, the parties entered bargaining for the subsequent 2024 to 2026 collective agreement. In an arbitration award dated December 16, 2023[231], Arbitrator Kaplan awarded wage increases totaling (with a 1% "administrative adjustment") 4.75% effective January 1, 2024 and a further 4.25% effective January 1, 2025. Moreover, in the course of reaching his award, the arbitrator noted as follows with respect to the economy:

> Ontario's economic situation is relevant and has been considered in arriving at outcome. The economy may be slowing, and provincial deficits impose real challenges to government spending. No one can rule out the possibility of a recession during the collective agreement term. However, and at the same time, persistent inflation has eroded, and continues to erode, spending power (and previous inflationary increases now appear to be fully baked into prices). Inflation may be deaccelerating but will come in above 3% in 2023. A return to targeted 2% inflation during the collective agreement term is aspirational. In the meantime, a demonstrated need to address inflation has been established and is reflected in voluntary sectoral settlements (and across the economy more generally). This point requires some elaboration.
>
> An examination of sectoral results, such as the freely bargained settlements at Bruce Power (as augmented by an operating COLA clause) and Hydro One (economic increases of 4.5% on April 1, 2023, 4.0% on April 1, 2024, and 3.5% on April 1, 2025), make it manifest that the increases that are being awarded here replicate free collective bargaining. I also note that the recent Electrical Safety Authority (ESA) agreement with the Society, which was reached after a nine-day strike, includes negotiated economic increases of 5.75% for 2023, 3.4% for 2024 and 2.85% for 2025, wherein the 5.75% includes a special one-time "administrative revision" to be added to the 2023 general wage increase.

360. As well, in April, 2023 after a nearly two-week strike, the Public Service Alliance of Canada ("PSAC") reached an agreement with the federal government. Like the PWU settlement, this settlement provided for 4.75% increases in 2022 and 3.5% in 2023. It also

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[231] *OPG v Society of United Professionals,* 2023 CanLII 120775 (ON LA), TAB 24 BOA.

provided for a one-time $2,500 pensionable lump sum payment and some other wage adjustments to specific classifications.[232]

361. In the CUPE and SEIU award, Arbitrator Kaplan noted in particular that that this kind of freely bargained outcomes, particularly after a lengthy strike, is excellent evidence of replication and therefore served as a "touchstone" for his award.[233]

362. In their most recent round of bargaining, the Canadian Association of Professional Employees ("CAPE") negotiated the same ATB increases and economic adjustments for its Economists bargaining unit as PSAC had negotiated following its strike.[234] Similarly, in their most recent round of bargaining, the Professional Institute of the Public Service of Canada successfully negotiated comparable increases to those achieved by PSAC and CAPE.[235]

363. Thus, the OMA submits that, while the energy and federal public sectors are not necessarily the most relevant comparator, the awards and settlements from these sectors have been relied upon as the results of free collective bargaining in inflationary circumstances, and therefore provide further evidence that the increases received by physicians in the 2021-2024 period are well below normative and catch up is required.

e) Post-Secondary Sector

364. Since Bill 124 was found to be unconstitutional, there have also been a number of settlements and awards in the post-secondary sectors which, again, demonstrate a pattern of increases in the 2021-2024 period well in excess of what OMA members have received.

365. For example, the University of Toronto Faculty Association was awarded an 8% ATB pay increase retroactive to July 1, 2022. As discussed above, this award is

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[232] Public Service Alliance of Canada, "Breaking down the gains in PSAC's Treasury Board settlement" May 6, 2023, TAB 112 BOD VOL 5.
[233] *CUPE/OCHU and SEIU, supra*, TAB 6 BOA.
[234] CAPE, EC Tentative Agreement (May 12, 2023), TAB 113 BOD VOL 5.
[235] PIPSC, IT Tentative Agreement Update (October 27, 2023), TAB 114 BOD VOL 5.

particularly relevant for present purposes with respect to the principle of catch-up, as Arbitrator Gedalof awarded the 8% in 2022 in order to catch up to inflation and comparators in light of the 1% and 1% awarded in the previous two years. This increase amounted a total 10% ATB for 2020-2023.[236]

366. For the province's college professors, OPSEU CAAT-A negotiated a reopener settlement that provide for the following salary increases, inclusive of the 1% originally awarded under Bill 124):[237]

- A 3% salary increase October 1, 2021;
- A 3% increase October 1, 2022; and
- A 3.5% increase October 1, 2023.

367. Most recently, York University Faculty Association ("YUFA") and all of the other bargaining units at York University negotiated a Bill 124 reopener settlement that provides for 2%, 3% and 4% increases (totaling 9%) for the three years impacted by Bill 124.[238]

368. These settlements and awards from the post-secondary sector further demonstrate that the increases received by physicians in the 2021-2024 period is far from normative, and that catch up is required.

f) Education Sector

369. The education sector affiliates, Elementary Teachers' Federation of Ontario ("ETFO"), Ontario English Catholic Teachers' Association ("OECTA"), the Ontario Secondary School Teachers' Federation ("OSSTF") and the Association des Enseignantes et des Enseignants Franco-Ontariens ("AEFO") have all agreed to interest arbitration in respect of their salary and wages for their contracts from September 1, 2022 to August 31, 2026. As of this writing, however, the arbitration hearings before Mr. Kaplan as chair have only been completed for OSSTF and ETFO and decisions are pending.

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[236] *University of Toronto, supra*, TAB 5 BOA.
[237] OPSEU, CAAT-A Bargaining Bulletin August 2023., TAB 115 BOD VOL 5.
[238] *York University and York University Faculty Association*, (unpublished award, April 13, 2024, Gedalof), TAB 25 BOA.

However, both affiliates have sought increases of 6%, 6%, 5% and 5% in each of the respective contract years.

370. ETFO and OSSTF have concluded their remedy arbitration under Bill 124. While the parties did accept a .75% increase in each of the 2019-2020 and 2020-2021 contract years, in addition to the mandated, 1%, they have also received an arbitration award[239] of 2.75% in addition to the mandated 1% for a total of 3.75%. Thus, over the 3 years of their contract, which overlaps to only a limited degree with the last OMA PSA, the members of the teaching affiliates received a total of 7.25%, not compounded. Again, this is significantly greater than the 4.8% under the 2021-2024 OMA PSA. However, it is significant that these education sector contracts largely cover period before the impact of inflation in late 2020 and 2021.

III. Comparison to Physicians in Other Provinces

371. Pursuant to section 25 of the Binding Arbitration Framework, comparability to physician compensation in other jurisdictions is another consideration which the Board may take into account.[240] It is also a factor, which the previous Arbitration Board looked to and accepted, noting for example that "Ontario doctors have had their compensation frozen, while their counterparts in other jurisdictions have seen increases."[241] In the OMA's submission the most compelling factor in this round of negotiations, and in particular in respect of the OMA's catch-up claim, is the gap between physician price increases and inflation over the past many years, and the increases awarded to hospital comparators in Ontario following the unconstitutionality of Bill 124. However, a review of increases awarded to physicians in other provinces is also warranted, bearing in mind theat the physician compensation increases in each province also reflect the unique health and broader public sector restraint initiatives and bargaining patterns in each province.

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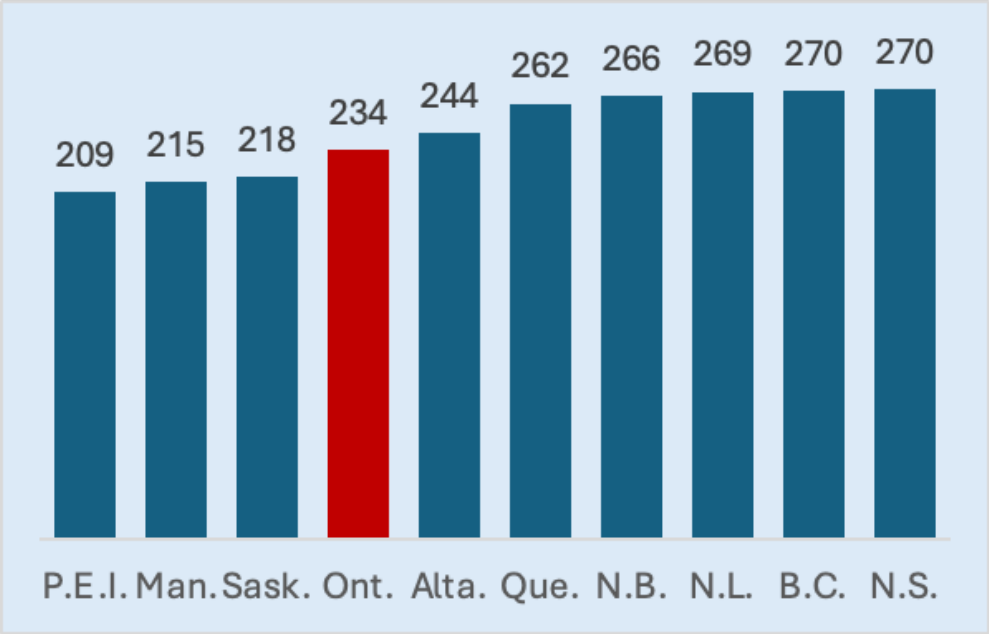
[239] ETFO and OSSTF, *supra,* TAB 2 BOA.
[240] BAF, *supra,* TAB 37 BOD VOL 1.
[241] 2019 Kaplan Arbitration Award, *supra,* TAB 1 BOA.

372. In the sections that follow, interprovincial income and fee comparisons are discussed globally, followed by a review of the various physician services agreements reached with respect to increases to fees and alternative payment plans in each of the provinces, and a comparison of average gross clinical payment and average fee for service. In contrast to other provinces, physicians in Ontario do not compare favourably.

373. As a starting point, it is important to note that Ontario has one of the highest population to physician ratios in the country.[124] Practically speaking, this means that every doctor in Ontario must provide services to more patients and work harder than the average physician in the rest of Canada. Their remuneration, however, does not reflect this reality. At the same time, Ontario has one of the highest costs of living in the country, second only to BC.[242] As a result, a physician's income in Ontario does not go as far as it does in other provinces. The OMA submits that both of these factors, physicians per population and comparative cost of living, must also be kept in mind when comparing physician compensation in Canada.

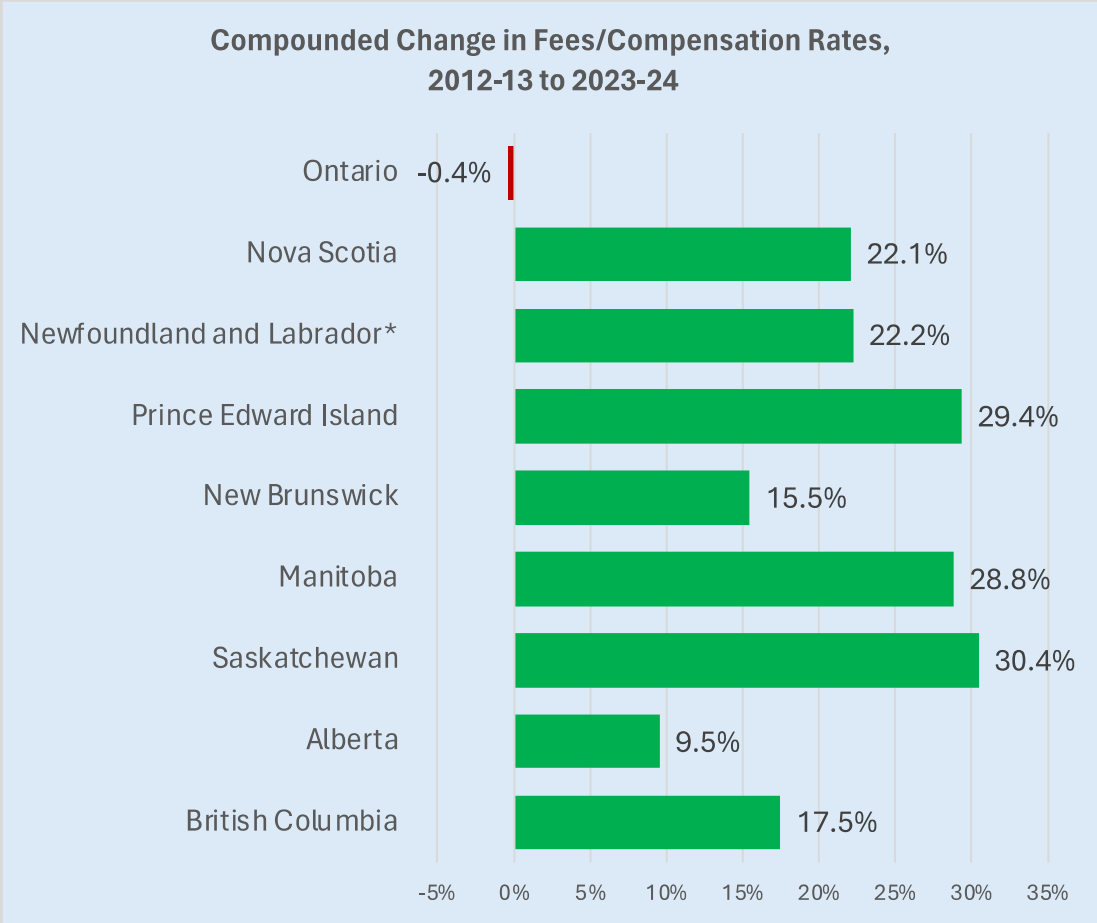
Number of total physicians per 100,000 population, by jurisdiction, Canada, 2022



[242] Amy Judd, "B.C. tops the list of the most expensive provinces in Canada: study," *Global News* (November 6, 2023), TAB 116 BOD VOL 5.

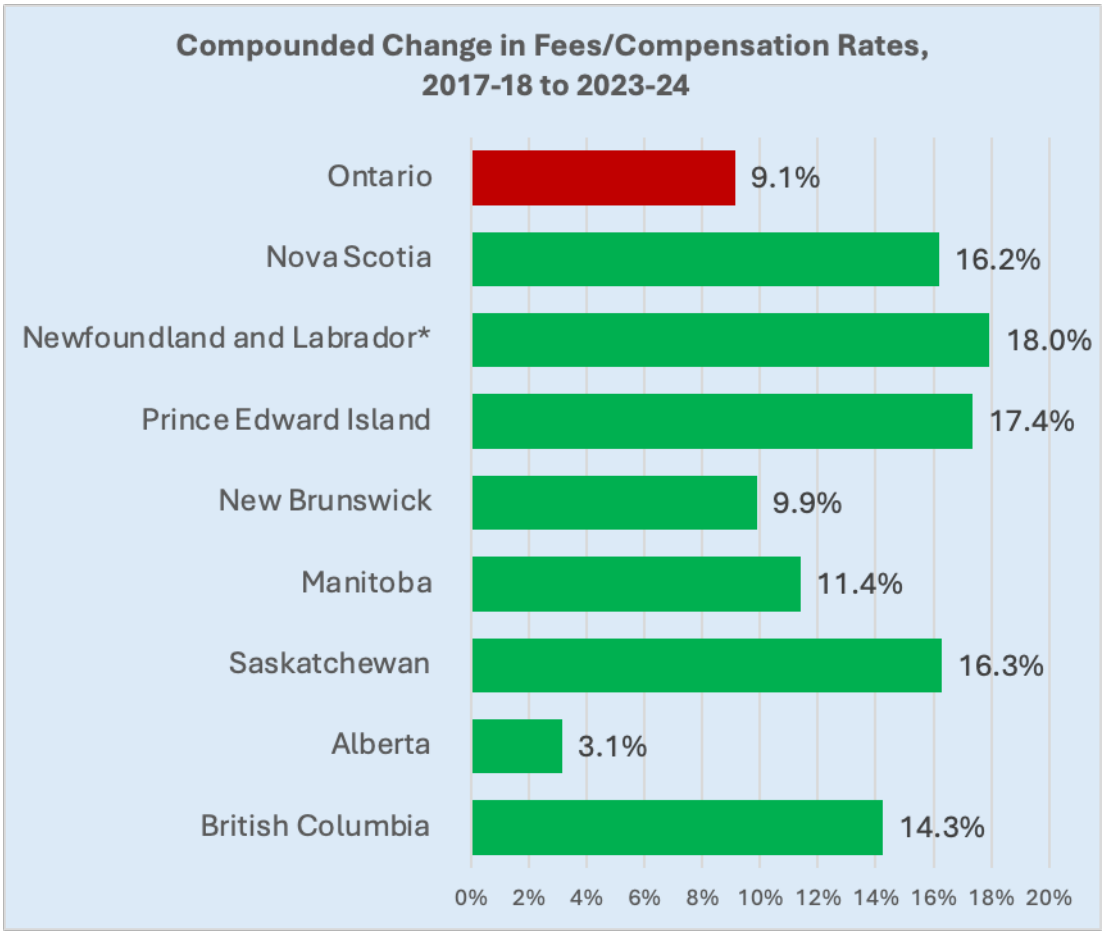
Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Data Tables. Ottawa, ON: CIHI; 2023. Table 23.0.

374. Since 2012, the point in time at which Ontario physicians began experiencing cuts to their income, physicians in other provinces have received regular normative compensation increases to fees and alternative payment plans, that have resulted in fee /compensation increases anywhere between 10-30% higher than Ontario. This fact is reflected in the following table:[243]



[243] Data Table showing Compounded Growth for Fee/ Compensation Rate Changes for All Provinces 2012-2023 ("Interprovincial Comparison Table"), TAB 117 BOD VOL 5. Note that this table does not include Quebec, which has not been a historic comparator between the parties. As well the fact that Quebec physicians have received increases in subsequent years for prior years, make it difficult to include in this type of summary comparative chart. *The above chart also does not include any 2023 increase for Newfoundland and Labrador, as that is still the subject of negotiation. Finally, the Ontario numbers do not include the 3.5% cut which was returned to Ontario physicians in 2019.

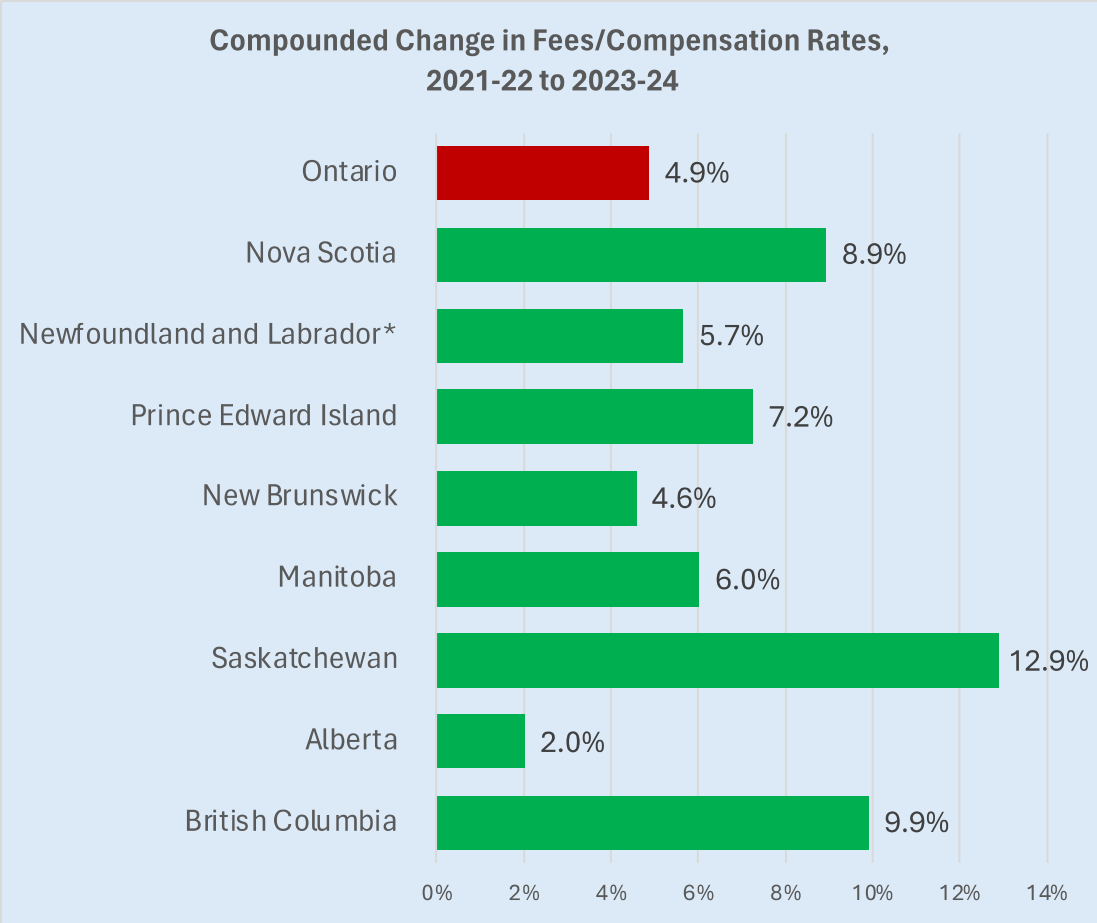
375. Even if one looks over a shorter time period in terms of fee/compensation increases, Ontario does not compare favourably. Looking back to 2017, the start date of the PSA that was last determined at arbitration, there is, for example, an up to 9% difference in the compounded change in fees/compensation rates between Ontario and Newfoundland, even before the not yet known 2023 increase for Newfoundland is included. As well, Ontario trails PEI by approximately 8%, Saskatchewan and Nova Scotia by approximately 7%, and British Columbia by approximately 5%.[244]



376. For the most recent PSA period of 2021-2024, physicians in a number of other provinces have also continued to fare better than physicians in Ontario. For example, physicians in Saskatchewan have received compounded fee/compensation increases in their agreement that have been 8% higher than Ontario over the same time period.

[244] *Ibid*.

Similarly, physicians in British Columbia and Nova Scotia have seen increases that are 5% and 4% higher respectively. Indeed, in every province except Alberta and New Brunswick, increases to physicians have exceed those paid in Ontario in the 2021-2024 period, as reflected in the following table:[245]



377. As well, many of the physician agreements with different provinces include additional compensation increases not captured by just a comparison of the global increases. As a result, it is helpful to also look in more detail at the agreements in each province.

[245] *Ibid*.

a) New Brunswick

378. After receiving no increases in 2012 and 2013, New Brunswick doctors have negotiated regular normative increases, including 2% for 2014-15 and 2% for 2015-16, along with a 0.6% one-time payment in 2014-15 and a 1.3% one-time payment in 2015-16.[246] In 2017, the New Brunswick Medical Society ratified a new four-year physician services master agreement that provides for fee-for service and salary increases of 1% for four years retroactive to April 1, 2016.[247]

379. The New Brunswick Physician Services Master Agreement is a 5-year agreement from April 1, 2020 to March 31, 2025. It included the following increases:[248]

- 2% increase for 2020/21;
- 1.5% increase for 2021/22;
- 1.5% increase for 2022/23;
- 1.5% increase for 2023/24;
- 1.5% increase for 2024/25.

380. As well, it included funding for targeted priorities including a new Provincial Hospitalist Program, enhanced funding for ICUs and emergency departments, and a commitment to enhance remuneration for anesthesiology.

b) Nova Scotia

381. Pursuant to the 2008 Physician Services Master Agreement, Nova Scotia doctors negotiated increases of 1%, 2% and 2% in 2012-13, 2013-14 and 2014-15 respectively. In 2016, Doctors Nova Scotia signed a new Physician Services Master Agreement with the Province with a term of April 1, 2015 to March 31, 2019 providing for 0% increases in each of 2015-16 and 2016-17 and 1% and 1.5% increases in 2017-18

[246] The amounts in 2014/15 and 2015/16 were for funds owed to New Brunswick doctors under previous contracts for under-utilized contracted programs.
[247] Government of New Brunswick, "New Release: Province and New Brunswick Medical Society ratify a new four-year agreement," TAB 118 BOD VOL 5.
[248] New Brunswick Physician Services Master Agreement, April 1, 2020 to March 31, 2025, TAB 119 BOD VOL 5.

and 2018-19 respectively. The rate increases apply for Insured Medical Services and Alternative Payment Plan annual rates.[249]

382. In 2019, the Nova Scotia government also announced investments of $39.6 million aimed at improving access to primary care, including fee increases of $11.3 million and $2.6 million increases for alternative payment plans.[250]

383. For the 2019-2023 period, physicians in Nova Scotia received increases of 2% a year.[251]

384. In August 2023, Doctors Nova Scotia ratified a new Physician Agreement with the provincial government. The 4-year agreement is effective April 2023 and includes funding for fee increases, investments in a new Longitudinal Family Medicine Payment Model as well as series of targeted investments in priority areas. The OMA estimates that the overall new funding under the agreement over the course of the 4 years to be in excess of $200M. This represents an overall increase of approximately 20% over the course of the PSA, or about 4.7% compounded annual growth.[252]

385. The agreement provides for the following fee increases:

> April 1, 2023 – March 31, 2027
> Year 1: 3%, Year 2: 3%, Year 3: 2%, Year 4: 2%
> Overall increase physician compensation over 4-year term expected to be 20% on a compounded basis (approximately 4.7% a year)

386. The agreement also provides for the following additional improvements:

> Family medicine:
> - New LFP Model to replace current APP model
> - Overhead/attachment fee $20 per patient (overhead) up to $40,000
> - "Invisible" work codes – seven new fee codes

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[249] Physician Services Master Agreement Between the Province of Nova Scotia and Doctors Nova Scotia Dated 9th September 2016, at para 4.1(b), TAB 120 BOD VOL 5.
[250] Government of Nova Scotia, "Investing in Family Doctors" (April 2018), TAB 121 BOD VOL 5.
[251] Doctors Nova Scotia, "Nova Scotia's doctors ratify new four-year contracts" Press Release (November 27, 2019), Tab 122 BOD VOL 5.
[252] Nova Scotia Government, "Province, Doctors Nova Scotia Reach New Four-Year Agreements" Press Release (July 20, 2023), TAB 123 BOD VOL 5; See also Doctors Nova Scotia, "Doctors accept new four-year contracts" Press Release (July 20, 2023), TAB 124 BOD VOL 5.

- APP rate for physicians with Focus Practice designation in geriatrics, palliative medicine or addiction medicine will increase to $310k

Specialist Care

- Process for expansion of APPs
- Succession planning – programs offers support for physicians who transition into and out of practice to overlap
- APP for general medicine at $421,425 per year
- $1,600 per day for physicians covering GIM and emergency department consults
- APP rate of $340k for geriatricians and palliative care specialists
- New hourly rates for emergency department physicians
- Practice Support ($25,000) and Retention Incentive ($16,000) for rural specialists
- "First Through the Door" incentive program is to support recruitment to core specialties in regional hospitals
- Increase On Call funding
- Parental Leave: $2,000/wk for 26 weeks
- Locum program: provincial program with increased funding
- Support for preceptorship including $5k lump sum payment for commitment to act as a preceptor in addition to 5% premium on FFS when working with learner and a $90/day stipend
- Virtual care: Physician to physician asynchronous billing
- Income stability – commitment to offer temporary APPs arrangements to FFS physicians who experience sustained income loss due to factors beyond their control.
- Physician Retirement Fund – details to be announced by March 31, 2024

c) Prince Edward Island

387. The previous Master Agreement between the Medical Society of Prince Edward Island ("MSPEI") and the government of Prince Edward Island and Health PEI provided for fee rate increases of 3.1% in 2012-13 and in 2013-14 and 3.7% in 2014-15, followed by 0% in both 2015-16 and 2016-17, 2.4% in 2017-18 and 1.6% in 2018-19 and global increases of 3% in 2017-18 and 2% in 2018-19 (which include fee rate increases).[253]

[253] Master Agreement between the Medical Society of Prince Edward Island and the Government of Prince Edward Island and Health PEI (April 1, 2015 to March 31, 2019), TAB 125 BOD VOL 5.

388. The most recent MSPEI Agreement is a 5-year agreement from April 2019 to March 31, 2024. It includes the following increases:

- 1.75% schedule of benefits increase for 2019-2020
- 2.36% schedule of benefits increase per year for 2020/21 through to 2023-2024

389. Negotiations for the new MSPEI Agreement to begin in April 2024 are on-going.

d) Newfoundland and Labrador

390. The 2013-2017 agreement between the Newfoundland & Labrador Medical Association ("NLMA") and the government of Newfoundland & Labrador[254] includes a 3.6% overall increase to compensation, and an equal dollar amount per Full-Time Equivalent (FTE) Physician distributed in two funding blocks:

- FFS Family Physicians: FTE amount approximately $10,500
- FFS Specialist Physicians: FTE amount approximately, $12,900

391. In addition, the agreement provides for a new Primary Care Renewal Program that is based on the British Columbia model of improving payments for comprehensive family practice and access combined with establishing new Family Practice Network ("FPN").[255] $4.5 million a year was specifically allocated to primary care renewal initiatives under the agreement.

392. Subsequently, the NLMA and the government of Newfoundland & Labrador entered into a 6-Year contract from October 1, 2017 to September 30, 2023. As part of the agreement, the parties negotiated a blended capitation model, a market adjustment for salaried physicians, on-Call maximums, Atlantic parity increases for groups that have fallen below and FFS increases range, by specialty, from 0% - 16.74%. The

[254] Newfoundland and Labrador Medical Association, "President's Letter: 2013-2017 MOA Update," (November 8, 2017), TAB 126 BOD VOL 5. See also: Memorandum of Agreement between Newfoundland and Labrador Medical Association & Government of Newfoundland and Labrador, dated December 6, 2017, TAB 127 BOD VOL 5.
[255] *Ibid.* at p. 11.

Newfoundland and Labrador Medical Association and the provincial government are currently engaged in negotiations over the terms of a new Physician Services Agreement.

e) Manitoba

393. In 2011, the Manitoba government and Doctors Manitoba negotiated a new four-year Master Agreement with the Province, effective April 1, 2011. The 2011 Agreement increased funding for medical services with a with a general rate increase of 10.6 % for physicians over the term of the contract (6.4% in third year of the agreement and 4.2% in the final year), with a similar increase to physicians in alternate payment plans and increases to the Physician Retention Fund.[256]

394. In February 2015, Doctors Manitoba signed a new Master Agreement with the province that ran from April 1, 2015 to March 31, 2019. It provided for increases of 1% a year in each of the agreement (2015-16, 2016-17, 2017-18, and 2018-19) for fee-for-service and for alternate funded agreements/payment arrangements, along with $33.5M in additional targeted money to priority areas, representing 5.26% over the four years[257]

395. In 2019 and 2020, physicians in Manitoba did not receive further increases. However, in August 2023, Manitoba's doctors ratified the largest agreement in province's history. The new agreement provided for an investment of $268M. It includes the introduction of a new Longitudinal Family Medicine Model and investments in specialty and hospital care. The $268M investment represents an estimated increase of 18-20% in the physician compensation over the term of the agreement.[258]

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[256] Manitoba, "News Release: Doctors Ratify New Four-Year Agreement with Manitoba Government" (October 7, 2011), TAB 128 BOD VOL 5; Government Employed Doctors Collective Agreement (Doctors Manitoba), April 1, 2011 to March 31, 2015, TAB 129 BOD VOL 5; see also Larry Kusch, "Just what the Doctors Ordered: Deal Aims to Keep Province Competitive" Winnipeg Free Press, (October 14, 2011), TAB 130 BOD VOL 5.

[257] Master Agreement Between Province of Manitoba and Doctors Manitoba (February 12, 2015) at para. 3.02 and 3.08, TAB 131 BOD VOL 5; see also Doctors Manitoba, Board of Directors Annual Reports 2014-2015, TAB 132 BOD VOL 5.

[258] Government of Manitoba, "Manitoba Government and Doctors Manitoba Reach Landmark Tentative Agreement" Press Release (July 20, 2023), TAB 133 BOD VOL 5.

396. Specific details of the agreement include the following:

- Term: October 1, 2023 – March 31, 2027
- Year 1: Market% (4.2%), Year 2: 2%, Year 3: 2%, Year 4: 2%
- Overall increase to physician compensation over 4-year term expected to be 18-20%
- $21,000 signing bonus. Retention payments to continue every 5 years and recognize up to 2 years of residency training
- Family Medicine:
    - New Family Medicine Plus model
    - Extended Visit Tariff for complex visits involving 2 or more complaints
    - Funding for focus practice areas (addictions, MAID, care of the elderly and other areas)
    - $3.50 per visit overhead (max 50)
    - Time-based stipend for indirect services
    - Panel Payment
- Specialty and Hospital Care
    - 15% premium to all in-patient and ER visits
    - Practice support premium will add $3.50 to in-person visits to help offset increasing overhead costs (max of 50 claims per day)
    - New surgical assistant model funding surgical assistants at 40% of surgeon rate (60% for specialist surgical assistants)
    - Investments to on call programs and alternative payment programs
- Rural and Northern
    - Rural and Northern Retention Fund of $25,000 paid every 3 years (in addition to current programs)
    - 35% fee premium to remote communities and 25% to other northern communities
    - Funding targeted to ensuring coverage in rural emergency departments
- Virtual care at 100% (including telephone)
- Lower deductible for CMPA
- Continuing CME rebates
- Increase from $1,500 to $2,000/wk for Parental leave 20 weeks.

- New Rural Retention
- Rural fee differentiation (35%)
- Equity, Diversity, Inclusion & Decolonization (more non-volume based pay and more funding to APPs used more commonly by female physicians)
- The agreement imposes a clear deadline for government to process billing claims with a clear joint dispute resolution process

f) Saskatchewan

397. The 2013-17 agreement for Saskatchewan doctors provided for a one-time lump sum payment of 1.5% for the amount billed for insured services April 1, 2013 and April 1, 2014, and for payment schedule adjustments of 1.95% and 2.95% as of October 1, 2015 and April 1, 2016 respectively, a total of 4.9%, at a time when Ontario physician fees were not only frozen but subject to unilateral across-the-board discounts and targeted fee cuts.[259]

398. This agreement also included a "continuation clause" so that the agreement remains in place until a new one is reached.

399. The 2017-2022 agreement included increases of 1%, 2% and 2% in 2019-20, 2020-21 and 2021-22 respectively.

400. In February 2024, Saskatchewan's physicians ratified a new 4-year Physician Services Agreement. The new agreement features a record setting increase in funding for physician services of approximately $245 million, which includes general rate increases and investments in other system priorities. One such priority is primary care, where there will be increases to team-based care and more stable funding to family physicians. Based on OMA's own analysis, investments made as part of this Physician Services Agreement are expected to increase compensation for Saskatchewan physicians by approximately 20%.[260]

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[259] Saskatchewan Medical Association, "Summary of a tentative agreement between the Saskatchewan Medical Association and Ministry of Health, 2013-14 to 2016-17," TAB 134 BOD VOL 5.
[260]Saskatchewan Medical Association, "Ministry of Health news release: Saskatchewan Doctors Ratify New Four-Year Contract" (February 5, 2024), TAB 135 BOD VOL 5.

401. Other specific details of the 2022-2026 agreements include the following elements:

- Overall fee increases
    - Year 1 – 5.5% (3% + 2.5% additional adjustment)
    - Year 2 – 3%
    - Year 3 – 2%
    - Year 4 – 2%
- $50M investment in a new primary care payment model for family physicians that unifies existing volume-based pay with a new capitation payment (based on patient contacts and panel size);
- An innovation fund of up to $10 million annually over the duration of the agreement, that will increase the amount of team-based care in primary health care settings;
- Funding to address gender pay inequity in physician fee codes, as well as new funding to support physician training and awareness related to equity, diversity, racism, and truth and reconciliation;
- A new Rural and Northern Practice Recognition Premium that recognizes the unique nature and critical importance of rural medicine;
- Introduction of permanent virtual care codes to increase efficient access to health services for patients and reduce unnecessary travel for appropriate services; and
- Increased funding to support long term retention, parental leave and continuing medical education.

g) Alberta

402. The 2011-2018 seven-year agreement between the Alberta Medical Association (“AMA”) and the government of Alberta (term April 1, 2011 to March 31, 2018) provided for no increases in the first 3 years (2011-12, 2012-13 and 2013-14), with the following increases to rates in the Schedule of Medical Benefit and Alternative Relationship Plan

and prices for all Physician Support Programs and Physician Assistance Programs for the next four years (2014-15 to 2017-18):[261]

- 2014/15: 2.5%;
- 2015/16: 2.5%;
- 2016/17: Cost of living adjustment ("COLA") (which ended up being 1.1%); and
- 2017–18: COLA (which ended up being 1.1%).

403. In 2016, following the crash in oil prices in 2014-15 and in the face of the resulting fiscal and economic crisis facing the Alberta government, the parties agreed to reopen and amend the 2011 agreement. At the end of the day, however, the primary effect of the 2016 amending agreement was to put the retention benefit at risk in 2016-17 and 2017-18 and also to put COLA at risk in 2017-18, if expenditures in those years exceeded an agreed to amount in comparison with the prior year (identified as the reconciliation gap).[262]

404. In 2018, the parties subsequently agreed to a two-year extension agreement, which provided for 0% increases for 2018-19 and 2019-20,[263] in line with all other settlements in the broader public sector in the province including nurses, in response to fiscal and economic challenges unique to Alberta. However, the agreement also provided that $90 million dollars of the $125 million hold-back (at risk dollars) for fiscal year 2017-18 would actually be paid to physicians with $45 million applied to the 2017-18 COLA increase (approximately 1.05%), $5 million to the AMA for physician grants, and $40 million to physicians to be distributed by AMA as it sees fit.[264]

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[261] Alberta Medical Association Agreement Between Alberta and the Alberta Medical Association, Effective April 1, 2011 (as amended by the 2016 Amending Agreement and the 2018 Amending Agreement), TAB 136 BOD VOL 6.
[262] *Ibid* at para 5(f)(g) and (h) [see 5. Financial].
[263] *Ibid.* at para. 5 b (iii).
[264] *Ibid* at para 5(j)). See also: Alberta Medical Association, "Overview: Tentative Agreement Package 2018-2020", TAB 137 BOD VOL 6; Alberta Medical Association, "Context & Highlights: Tentative Agreement Package of Proposed Amendments to AMA/AH/AHS Agreements, TAB 138 BOD VOL 6; AND Alberta Medical Association, "Questions and Answers About the Tentative Package," Updated May 10, 2018, TAB 139 BOD VOL 6.

405. The parties also agreed to 0% in 2020-21 and 2021-22.

406. The most recent AMA Agreement is a four-year contract ratified from April 1, 2022 – March 31, 2026.

407. It provides for overall fee increases of 1% for the first three years (2022-23-2024-25) with the fourth-year (2025-26) to be based on a market rate review that precedes global increase negotiations, with mediation/binding arbitration, if required.

408. The agreement also included the following:[265]

- $40M investment in PCN models and commitment to review capitation funding
- Business Cost Program - +$3.59 per office visit (up to 50/day)
- Reinstatement of $1,000 Medical Liability Reimbursement ("MLR") deductibles; program administration returns to the AMA
- Reinstatement of the CME program. Benefits set at $2,200 per year per qualified physician
- $15M per year for recruitment and retention of physicians in underserved areas
- Additional $12 million per year to improve access in underserved areas (primarily via Rural, Remote, Northern Program)
- $2 million per year for the Rural Education Supplement and Integrated Doctor Experience program.
- New program to address payments for care provided to patients without health coverage.

409. Even through Alberta's current Physician Services Agreement is not set to expire until April 2026, Alberta government has recently announced a new additional investment of $200 million in primary care.[266]

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[265] Alberta Ministry of Health and Alberta Medical Association Agreement, April 1, 2022, TAB 140 BOD VOL 6.
[266] Government of Alberta, "New funding to stabilize primary health care," (December 21, 2023), TAB 141 BOD VOL 6; Government of Alberta, "Stabilizing Alberta's primary health care system," (April 4, 2024), TAB 142 BOD VOL 6.

h) British Columbia

410. In 2014, in the face of the BC government's ongoing fiscal restraint policy, Doctors of BC negotiated a new Physician Master Agreement with the Province of British Columbia.[267] This agreement provided for a one-time payment of 0.5% of the amount of their payments during the 2014-15 fiscal year from a variety of sources, including fees, sessional contracts, service contracts and salary agreements. For each of the subsequent years of the agreement, (2015-16, 2016-17, 2017-18, and 2018-19) the agreement provided for a 0.5% increase to fees, sessional contract rates, service contract ranges and rates, and salary agreement ranges and rate.

411. In addition, further to a letter of agreement annexed to the Master Agreement, BC physicians also received an Economic Stability Dividend ("ESD") in each of 2015-16, 2016-17, and 2017-18; 2018-19. The ESD is applied as a percentage increase to fees, sessional rates, service contract ranges and rates, and salary agreement ranges and rates. The ESD was 0.45% in 2015-16, 0.35% in 2016-17, and 0.4% in 2017-18 and 0% in 2018-19.

412. As well, the agreement provided an additional $294.9 million (approximately 7.4%) to address a range of issues, including benefits, disparity correction, recruiting new physicians, rural issues, facilitating engagement of physicians in health authority facilities, and improving access for patients to family doctors.[268] The $294.9 million included a combination of compensation and system improvements. Despite the fact that the government mandate at the time was 5.5%, ultimately the total agreement exceeded that mandate.

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[267] 2014 Physician Master Agreement Between the Province of British Columbia and British Columbia Medical Association and Medical Services Commission, Effective April 1, 2014 at Appendix F "Adjustments to Fees, Service Contract Ranges, and Service Contract Rates, Salary Agreement Ranges and Salary Agreement Rates, and Sessional Contract Rates" and Appendix I "Letter of Agreement – Economic Stability Dividend", TAB 143 BOD VOL 6.

[268] 2014 British Columbia Physician Master Agreement, *ibid*.

413. The 2019 Physician Master Agreement included fee increases of 1.7% in 2019-20 and 0.8% in 2020-21 and 2.4% in 2021-22.[269]

414. More recently, in December of 2022, Doctors of BC, ratified a new 3 year Physician Master Agreement.[270] The agreement is effective April 1, 2022 and includes a new investment of over $700 million per year. This investment represents a 13.2% increase over the course of the 3 years. The agreement, also allows for additional increases of up to 2.25% contingent on the growth in Consumers Price Index over the term of the agreement, which recognizes implicitly the importance of addressing inflation. It is the OMA's understanding that the government has now agreed to apply this Cost of Living clause as outlined in Appendix J of the Physician Master Agreement, for both years of the agreement, so that the additional 2.25% increase is expected to be applied to various fees.

415. Specifically, the 2022 PMA provides as follows:

- Total compensation increases:
  - Year 1: 4.0%;
  - Year 2: 6.5% - up to 7.5% with COLA; and
  - Year 3: 2.7% - up to 3.7% with COLA

- Fee increases (40% of total funds):
  - 3.0% April 1, 2022;
  - 2.0% April 1, 2023; and
  - 1.0% April 1, 2024.

- Sections to determine allocations but may only allocate funding to existing fee items or for fees ready for implementation

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[269] 2019 Physician Master Agreement Between the Province of British Columbia and British Columbia Medical Association and Medical Services Commission, Effective April 1, 2019, TAB 144 BOD VOL 6.

[270] 2022 Physician Master Agreement Between the Province of British Columbia and British Columbia Medical Association and Medical Services Commission, Effective April 1, 2022, TAB 145 BOD VOL 7.

- The remaining 60% of the funding is targeted to areas Doctors of BC identified as priorities, including:
    - Increasing the Business Cost Premium for all and expanding it to include hospital income for specialists with community offices. Paid to physicians who are responsible for operating costs of community offices
    - Addressing income disparities among specialists
    - Developing new fees for specialists
    - Recognizing after-hours work and addressing disparities for AP (alternately paid) physicians
    - Supporting family physicians who provide community longitudinal family practice (discussed further below)
    - Modernizing the BC Family Doctor Fee Guide to simplify the process and address equity
    - Improving retirement savings and parental leave benefits
    - Funding to address workload challenges (including current backlogs and anticipated workload growth) for Service Contract and Salaried physicians
    - Additional investments in Continuing Medical Education, Physician Disability Insurance Program, Parental Leave Program, Contributory Professional Retirement Savings Program and CMPA rebate program
    - 10% increase to On Call program and 25% increase to tray fee program
    - New funding for Palliative Medicine, after-hour procedures
    - Continuation of virtual care and bilateral process for implementing any amendments to virtual care fees

416. With respect to the new Longitudinal Family Practice Model, since its launch, 4,000 family doctors have enrolled. The OMA estimates that the introduction of the LFP model represents an additional investment of upwards of $400M. As this is in addition to the $700 million in the PSA, the total increase in expenditures to BC physicians approximately $1.1 billion or 20% over the term of the agreement.[271]

[271] Doctors of BC, "Celebrating the one-year anniversary of the Longitudinal Family Physician Payment Model | Doctors of BC" (February 7, 2024), TAB 146 BOD VOL 7.

417. Thus, when the normative compensation increases for doctors in other provinces are compared to Ontario since 2012, Ontario is anywhere from 10-30% behind those other provinces. Even if one looks over a shorter period, the increase in Ontario is less than those provided in the majority of other provinces.[272] The OMA submits that its proposal should be awarded in order to rectify this situation and allow Ontario to catch-up to a key comparator.

i) Gross Clinical Payments

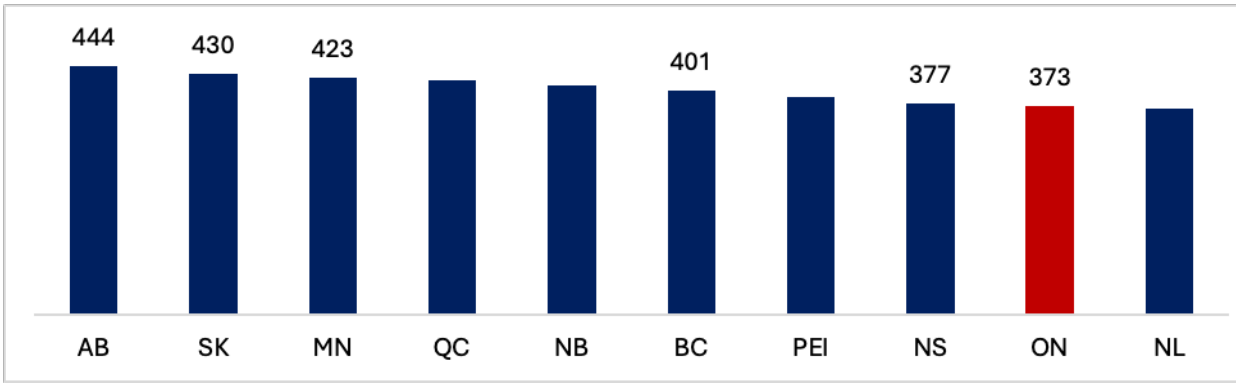
418. Separate and apart from the details of each provincial agreement, it is important to compare physician compensation across provinces by looking at changes in average gross clinical payments. From a comparative perspective, in relative terms, average gross clinical payment per full-time equivalent physician in Ontario is among the lowest in the country, as seen in the following chart.[273] It is about 12.8% lower than the weighted average of its main competitor provinces (Alberta, B.C., Manitoba, and Saskatchewan).

Gross Clinical Payment per Full-Time Equivalent, by jurisdiction, Canada, 2021-22

[272] See Data Table showing Compounded Growth for Fee/ Compensation Rate Changes for All Provinces 2012-2023 ("Interprovincial Comparison Table"), TAB 117 BOD VOL 5. Note that this table does not include Quebec, which has not been a historic comparator between the parties. As well the fact that Quebec physicians have received increases in subsequent years for prior years, make it difficult to include in this type of summary comparative chart. *The above chart also does not include any 2023 increase for Newfoundland and Labrador, as that is still the subject of negotiation. Finally, the Ontario numbers do not include the 3.5% cut which was returned to Ontario physicians in 2019.

[273] Under the CIHI methodology, gross clinical payment is calculated for each physician. The 40th and 60th percentile of the distribution of gross clinical payments is then calculated. The FTE is then assigned to each physician as follows. If the physician gross payment is between the 40th and 60th percentile, the physician is considered 1 FTE. If the physician gross payment is below the 40th percentile, then the physician is assigned an FTE equal to her gross payment divided by the gross payment for the 40th percentile. Lastly, if the physician gross payment is above the 60th percentile, then the physician is assigned an FTE equal to 1 plus the log of her gross payment divided by the gross payment for the 60th percentile; See Canadian Institute for Health Information. "Approaches for Calculating Average Clinical Payments per Physician Using Detailed Alternative Payment Data. Ottawa," ON: CIHI; 2015, TAB 147 BOD VOL 7.

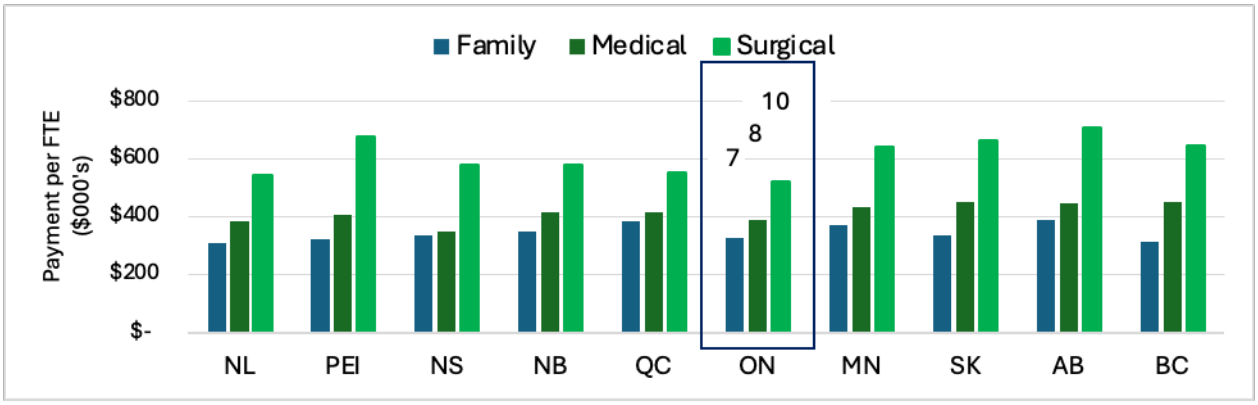
Payment per FTE ($000)



Source: Canadian Institute for Health Information. National Physician Database — Payments Data, 2021–2022. Ottawa, ON: CIHI; 2023.

419. When gross clinical payment per full-time equivalent physician in Ontario is looked at by specialty, Ontario ranks 10th in the country for payments to surgical specialties, 8th in the country for payments to medical specialties and 7th in terms of overall payments to family physicians.

Payment per FTE ($000), by Specialty Group

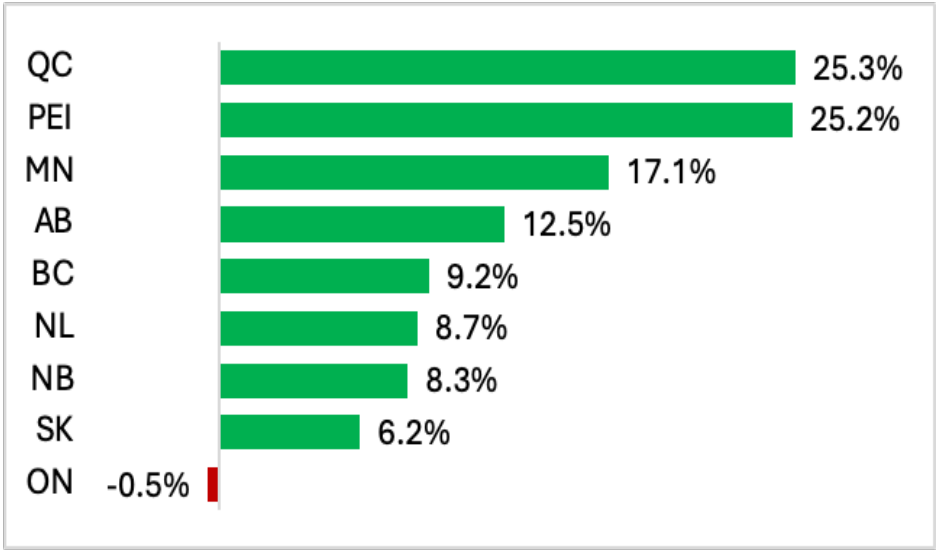


Source: Canadian Institute for Health Information. National Physician Database — Payments Data, 2021–2022. Ottawa, ON: CIHI; 2023.

420. The fact that gross clinical payments per full-time equivalent ("FTE") physician is relatively low compared to other provinces is in large part because Ontario has experienced the lowest growth in payment per physician in the country since 2011-12. As seen in the following chart, a comparison of average gross clinical payments per physician in 2011-12 to 2021-22 by province reveals that the payments to Ontario doctors

have declined while payments in all other provinces have increased, in some cases significantly so (i.e. by up to 25%):

Percent Change in Gross Clinical Payment per Physician, by jurisdiction, Canada, 2021-22 vs. 2011-12

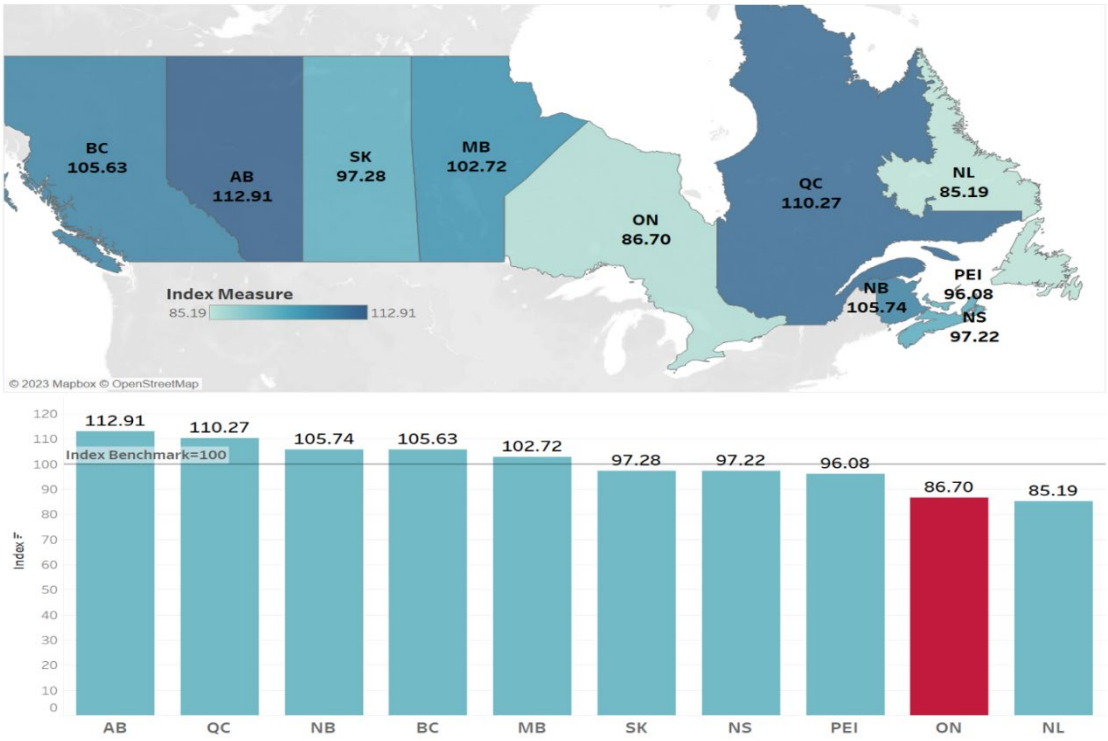


Source: Canadian Institute for Health Information. National Physician Database — Payments Data, 2021–2022. Ottawa, ON: CIHI; 2023.

j) Average Physician Fees

421. As well, physician fees in Ontario are also among the lowest in the country. The average fees in Ontario are about 23.7% lower than the MD-weighted average of its main competitor provinces (Alberta, B.C., Manitoba, and Saskatchewan).

Average Fee for Service, by jurisdiction, Canada, 2021-22



Source: Canadian Institute for Health Information. Physician Services Benefit Rates, 2021–2022. Ottawa, ON: CIHI; 2023.

422. This interprovincial comparison in all likelihood understates the true deterioration of relative economic position of physicians in Ontario, given that it does not yet incorporate fee increases in physician agreements in other provinces for fiscal years 2022-23 and 2023-24.

423. In conclusion, a comparison of fee/compensation increases to physicians across the country since 2012, together with a comparison of average gross clinical payments for all physicians both now and historically as well as a comparison of average fees for services all reveal that Ontario trails almost all other provincial comparators. The OMA's proposed Year 1 increase is thus supported by the higher increases negotiated by physicians in other provinces, including since 2012, and by the fact that the average gross clinical payment and average fees are lower in Ontario.

C. GENERAL INCREASE FOR 2024-25

424. Alongside catch-up for losses both against inflation and against relevant comparators to date, discussed above, and money for targeted proposals, discussed further below, the OMA's Year 1 proposal includes a 5% general price increase for 2024-25. This 5% increase is designed to cover inflation over the course of the year and also to provide a modest increase to real income, something that physicians have not seen for a very long time and address the systemic retention and recruitment crisis in medicine generally.

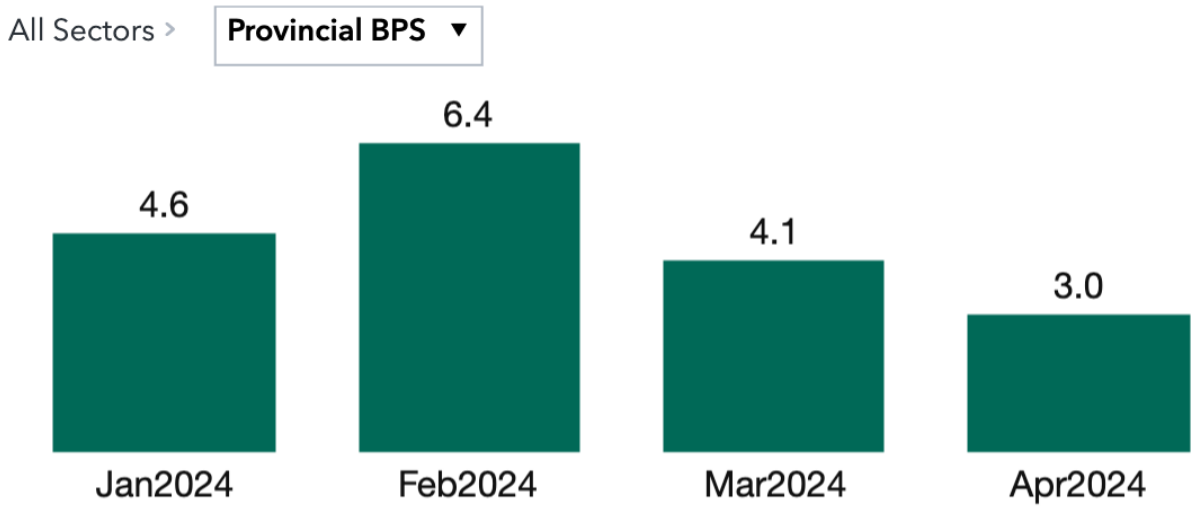
425. Inflation is not only a problem of the past but is also predicted to continue into the short to medium term and thus needs also be addressed for the first year of the 2024-2028 PSA. Looking at the most recent inflation numbers, inflation in Ontario was 2.9% in January 2024, 2.8% in February 2024 and 2.6% in March 2024.

426. A 5% increase is intended to address a number of pressing issues: the ongoing reality of inflation in Year 1; the need to provide physicians with some relatively modest increase over and above inflation to enable their incomes to grow and not keep them "running in place", financially; the overall history of physician compensation increases (reviewed in Part Five above); and the real and critical need to begin to resolve the recruitment and retention issue (reviewed in Part Seven above) to provide some incentive to physicians, admittedly as only part of the overall solution, to remain in practice and entice new physicians to enter into the areas of practice in which there are critical needs (virtually all). If the crisis in health care is to be addressed—and it must be addressed--appropriate and meaningful increases must be provided in Year 1.

427. The proposed 5% increase is also consistent with recent and current general bargaining trends. According to data from the Ministry of Labour's Collective Bargaining Ontario site, the bargaining trend for average annual increases in the provincial broader

public sector ("BPS") was 4.6% in January 2024, 6.4% in February 2024, 4.1% in March 2024. These agreements from the first quarter cover 16,000 BPS employees.[274]

428. The following table and chart, breaks the average annual increases down by the month in which the agreements were ratified:[275]



	Number of Settlements	Number of Employees	Avg. Annual Increase (%)	
Provincial BPS	79	56,719	3.7%	
Jan2024	3	787	4.6%	
Feb2024	6	9,549	6.4%	
Mar2024	5	5,905	4.1%	
Apr2024	65	40,478	3.0%	

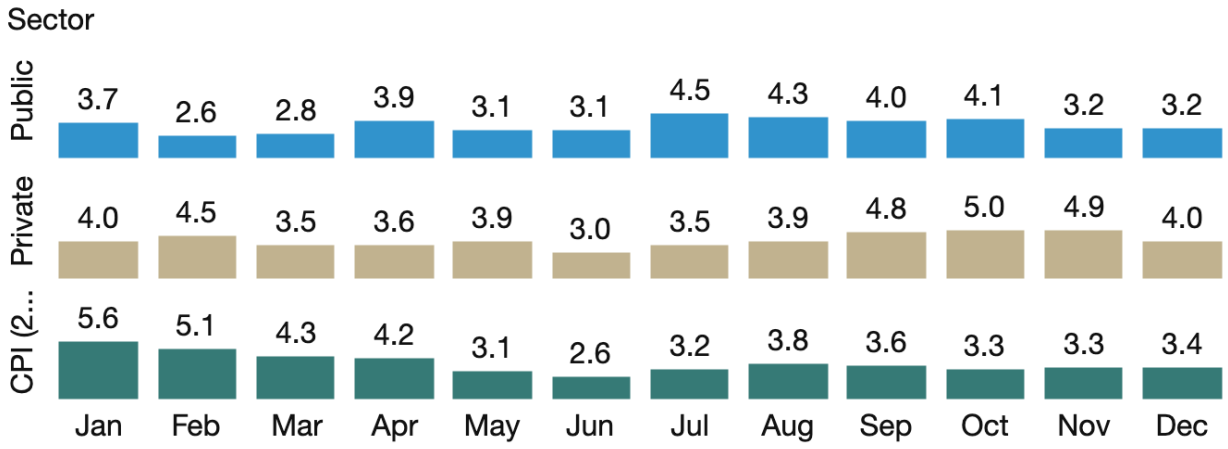
429. These increases are in line with what the OMA is seeking as part of the proposed general increase for 2024-2025, although the OMA's proposal is also justified by the

[274] Collective Bargaining Ontario, Collective Bargaining Highlights: Overview of Wages, Average Annual Base Wage Increases % by Sector, Provincial BPS, accessed April 30, 2024.
[275] *Ibid.*

overall crisis in the health care sector, the appropriateness of real increases for physicians' net of inflation, and the historic catch-up justification reviewed above.

430. In 2023, the bargaining trends for average annual wage increases in both public and private sector settlements were in the 3.5-5% range:[276]

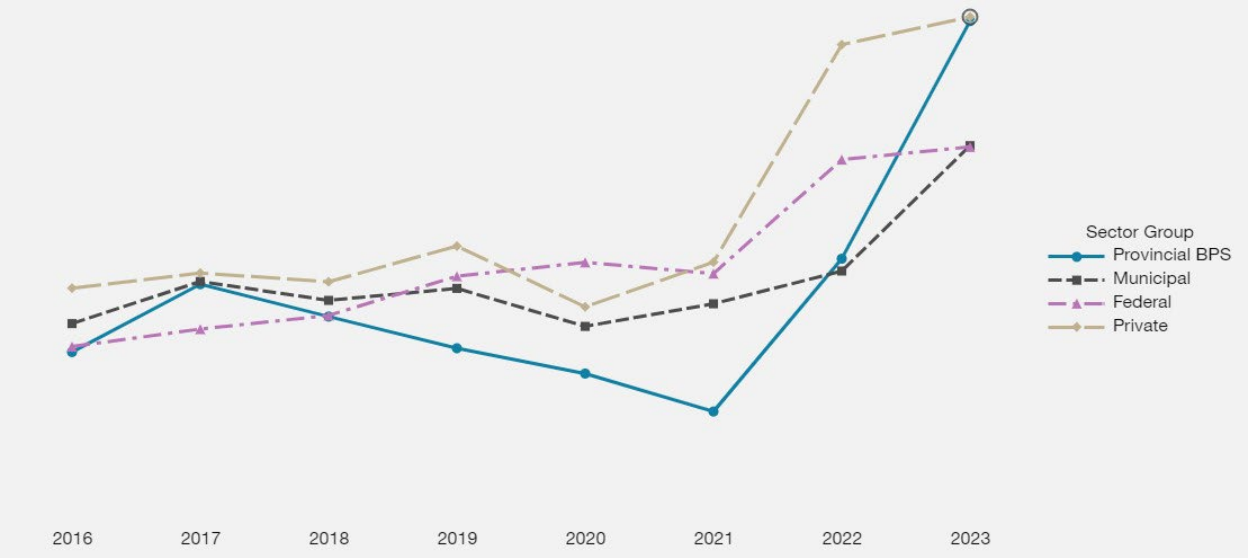
Collective Bargaining Highlights: Average Annual Base Wage Increases (%) By Sector vs. the Consumer Price Index ("CPI") (2023)



431. Notably, for 193 Broader Public Sector agreements ratified in 2023, the average percentage general wage increase was 4.2%. Similarly, 4.2% was the average percentage general wage increases for private sector contracts. These increases and the number of employees that they apply to in each sector are set out in the graph and table below:[277]

[276] Collective Bargaining Ontario, Collective Bargaining Highlights: Average Annual Base Wage Increases (%) By Sector vs. the Consumer Price Index (CPI) (2023) accessed April 30 2024.
[277] *Ibid*.

Collective Bargaining Highlights: Trends of the Average Annual Base Wage Increases (%) by Sector 2016 to Date



Ratification Year	Increase (%)	Sector Group	Number of Settlements	Number of Employees
2023	4.2	Provincial BPS	193	151,880
2023	3.1	Municipal	40	18,723
2023	3.1	Federal	13	44,437
2023	4.2	Private	55	65,048

432. Settlements in the private sector are trending even higher. For example, the 2023-26 settlement between Unifor and Ford provides for a wage increase of 10% in the first year, 2% in the second year and 3% in the final year. As well, the settlement provides for the base rate for hourly wages to increase by 25% for those with a skilled trade, a reactivated cost-of-living allowance, a $10,000 bonus, two new paid holidays and pension improvements.[278]

433. The agreement between West Jet and the Air Line Pilots Association, International ("ALPA"), includes even higher wage increases, reflecting in part the shortage of pilots.

[278] Unifor, "Unifor members ratify collective agreement with Ford Motor Company," (September 24, 2023), TAB 148 BOD VOL 7.

Under their settlement, pilots receive a 15.5% pay increase in the first year, along with a further 8.5% over the remainder of the contract, from 2024 to 2026.[279]

434. In the construction sector, increases have also been significantly higher, some of which are reviewed in the interest arbitration award between *LiUNA – Local 183 and TRCLB and DRCLB and MTABA dated May 3, 2022*, (unpublished).[280]

435. Recently, CUPE received a 3% salary increase, in addition to premium and other benefit improvements, for a year which partially overlaps with Year 1 of the 2024-28 PSA. It is to be noted, however, that the hospital sector unions received retroactive increases as part of the remedy under Bill 124, which also addressed issues related to recruitment and retention.

436. The OMA does not have a reopener, and so unlike the hospital unions and others, cannot receive retroactive increases over the 2021-24 period. Moreover, the OMA's catchup proposal of 10.2% is intended to address losses due to inflation over the 2021-2024 PSA as well as prior losses vis a vis both inflation and comparators since 2012, in part caused by the absence of a meaningful bargaining process.

437. As a result, the OMA's proposal for a 5% the Year 1 general increase is supported by continuing to at least partially further make up for losses suffered since 2012, and by the need for increases which respond the physician recruitment and retention crisis as well as very serious other challenges facing physicians, as outlined above.

438. If there is to be any real progress in meeting the health care needs of Ontarians, if there is to be any real improvement in the retention and recruitment crisis of physicians undoubtedly facing Ontario, there must be a significant and meaningful general price increase for Year 1 of the PSA. As well, as set out in Part Nine below, it is also critical that there be further targeted investments in physician services.

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[279] CBC, *WestJet pilots deal grants 24% pay raise over four years* (May 26, 2023), TAB 149 BOD VOL 7.
[280] *LIUNA – Local 183 and TRCLB and DRCLB and MTABA* dated May 3, 2022, (unpublished) at para 42, TAB 26 BOA.

PART NINE - TARGETED INCREASES

A. OVERVIEW

439. The Process Agreement identifies that the parties devote 30% of the Year 1 Award to addressing targeted increases, some of which are listed in the Process Agreement in no particular order of priority. For many years, and as detailed above certainly since 2012, the government has failed to provide the necessary funding support and investments in a range of essential physician services critical to providing necessary medical care to the people of Ontario. For this reason, the OMA has identified a number of areas which require increased and specific investment in order to address these chronic systemic needs.

440. The full range of the OMA proposals for targeted increases over the life of the PSA are set out below. However, the parties have engaged in very little, if any, substantive discussions or bargaining to this point over the OMA's proposed targeted changes; indeed, in virtually all cases, the government has not meaningfully responded to or engaged with the OMA's proposals. The OMA continues to reserve its right to modify its proposals as the subsequent negotiations and mediation arbitration process unfolds, and in response changing circumstances and in view of the government's position.

441. The following is a summary of the OMA position on each proposal in order to provide the board with a general sense of both the nature and extent of the increases being sought by the OMA, and the rationale for those changes. Furthermore, if it becomes necessary to arbitrate the proposed targeted increases, the OMA reserves the right to make more extensive and detailed submissions.

442. The parties are not asking that the issue of targeted increases being addressed in the initial phase of the Year 1 arbitration, and indeed they have agreed that they will not be so determined. Once the amount of the Year 1 increase has been determined, the parties will attempt to agree on the specific targeted increases that are to be implemented and the amount to be allocated to each of them. Any disputes with respect to these issues will be submitted to the Board of Arbitration for final and binding determination. As is

apparent from the following, however, the OMA has identified some areas which can be and should be addressed immediately.

443. Finally, with respect to all of the OMA's targeted proposals, the OMA proposes that any implementation disputes, including any disputes arising over the amount of funding or its allocation, can be submitted at the request of either party to William Kaplan, or such other arbitrator as the parties may agree, as sole arbitrator for a final and binding determination on an expedited basis.

B. FINANCIAL AGREEMENT: TARGETED INVESTMENTS

I. Introduction

444. In addition to the global normative increases, the OMA's proposes additional targeted investments towards redressing the gender pay gap, medical innovation and technological advances, complexity of patient care and OHIP Schedule modernization.

445. Specifically, the OMA is proposing an additional amount of 1% (or about $160 million dollars) for addressing the gender pay gap, 1% for new services resulting from medical innovation/technological advances, 1% related to complexity of patient care, and 1.5% to fund modernization initiatives that affect more than one physician specialty or group (e.g., including unbundling of post-operative care from the surgical fee, and a consultation and visits fee relativity exercise, including consideration of time-based fee codes).

446. It is important that this targeted funding be made available as soon as possible, so that the process of implementing these necessary changes to the OHIP Schedule can begin effective April 1, 2025. In order to meet this implementation timetable, these funds must be secured in Year 1 of the 2024-25 PSA.

447. Under this approach, the Physician Payment Committee ("PPC") will be given the mandate to make recommendations to the PSC on each of the four targeted investment areas, with the objective of implementing necessary changes from the Year 1 funding effective April 1, 2025.

448. The PPC's work will include reviewing proposals for changes in each of these areas from physician sections or groups. The OMA proposes that any unused amounts from any one of targeted investments would flow into other targeted investments (on agreement of the parties), with any remaining unused funds, if any, flowing generally to increases to fees under the OHIP Schedule, with related flow-through funding to non-fee for service payments.

449. The PPC is a bilateral committee with equal representation from the OMA and the MOH with the mandate to recommend amendments to the OHIP Schedule. Under the terms of the 2021-24 PSA, the PPC's mandate includes recommendations for the addition, revision, and deletion of fee codes in the OHIP Schedule, having regard to such factors as time, intensity, complexity, risk, technical skills, and communication skills required to provide each service, as well as proposals on the flow through to non-fee-for-service payments. In carrying out its mandate, the PPC is already directed to take such steps as are necessary to "modernize" the OHIP Schedule, to achieve gender pay equity, and to address medical innovation/technological advances. However, without targeted funding, these agreed to priorities simply cannot be addressed, particularly since the fee increases otherwise sought by the OMA for Year 1 (10.2% for catch-up, and 5% for the Year 1 general increase) are necessary to ensure that the price of physician services is appropriately increased and does not include consideration of the need for further targeted funding in these priority areas.

450. Indeed, the PPC currently has over 600 fee proposals before it, many of which fall into one of the targeted investment categories identified above and that have been deferred in the absence of sufficient targeted funding.

II. Gender Pay Gap

451. The existence of gender-based disparities in physician payments is well established both internationally[281] and in Ontario.[282] Steffler et al., 2021 studied physician

[281] Theurl E, Winner H. The male-female gap in physician earnings: evidence from a public health insurance system. Health Econ. 2011 Oct;20(10):1184-200. doi: 10.1002/hec.1663. Epub 2010 Sep 19. PMID: 20853520, TAB 150 BOD VOL 7; Magnusson, C. (2016). The gender wage gap in highly prestigious occupations: a case study of Swedish medical doctors. Work, Employment and Society, 30(1), 40-58. https://doi.org/10.1177/0950017015590760, TAB 151 BOD VOL 7; Dumontet M, Le Vaillant M, Franc C. What determines the income gap between French male and female GPs—the role of medical practices. BMC Fam Pract. 2012;13(1):94. doi:10.1186/1471-2296-13-94, TAB 152 BOD VOL 7.

[282] Buys YM, Canizares M, Felfeli T, Jin Y. Influence of age, sex, and generation on physician payments and clinical activity in Ontario, Canada: an age-period-cohort analysis. Am J Ophthalmol. 2019;197:23-35. doi:10.1016/j.ajo.2018.09.003, TAB 153 BOD VOL 7; Cohen M, Kiran T. Closing the gender pay gap in Canadian medicine. CMAJ. 2020;192(35):E1011-E1017. doi:10.1503/cmaj.200375, [Cohen & Kiran, 2020], TAB 154 BOD VOL 7; Dossa F, Simpson AN, Sutradhar R, et al. Sex-based disparities in the hourly earnings of surgeons in the fee-for-service system in Ontario, Canada. JAMA Surg. 2019;154(12):1134-1142. doi:10.1001/jamasurg.2019.3769, [Dossa et al, 2021] TAB 155 BOD VOL

earnings in Ontario using all OHIP billings and found that the unadjusted differences in clinical payments between male and female physicians were 32.8% annually and 22.5% daily. After accounting for practice characteristics, region, and specialty, a 13.5% gender pay gap remained.

452. Further, work in Ontario has found that female surgeons receive fewer referrals than male surgeons throughout their career, irrespective of experience[283] and that hourly earnings for female surgeons were lower than for male surgeons, all else equal, as female surgeons more commonly perform lower paying procedures per unit of time.[284]

453. One mechanism identified as a potential driver of such gender inequities in specialist billings is referral bias. Chami et al. (2023) found that male specialists in Ontario received more referrals than did female specialists, with males receiving higher average revenue per referral.[285] While both males and females tended to refer more often to specialists of the same gender, the overall odds of referring to a male specialist remained higher. While the underlying reasons for the bias in referral patterns are not well understood, the evidence seems to suggest that female surgeons experience more severe repercussions from referring physicians after negative surgical outcomes (e.g., patient death) than male surgeons.[286] Other possible explanations for referral bias include the role or preference of patients and hospital administrators, as well as the fact that physician education pathways still remain poorly understood.

454. While the OHIP Schedule itself is theoretically blind to physician gender and other personal physician characteristics, evidence of billing disparities between male and female physicians persists in fee-for-service settings. Studies have shed light on some

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7; Kralj B, O'Toole D, Vanstone M, Sweetman A. The gender earnings gap in medicine: Evidence from Canada. Health Policy. 2022 Oct;126(10):1002-1009. doi: 10.1016/j.healthpol.2022.08.007. Epub 2022 Aug 17. PMID: 35995639, TAB 156 BOD VOL 7.

[283] Dossa et al, 2021, *supra,* TAB 155 BOD VOL 7.

[284] *Ibid.*

[285] Chami N, Weir S, Shaikh SA, et al. Referring and Specialist Physician Gender and Specialist Billing. *JAMA Netw Open.* 2023;6(8):e2328347. doi:10.1001/jamanetworkopen.2023.28347 [“Chami et al., 2023”], TAB 157 BOD VOL 7.

[286] Sarsons H. Interpreting Signals in the Labor Market: Evidence from Medical Referrals [Job Market Paper]. Working Paper, [“Sarsons et al., 2017”] TAB 158 BOD VOL 7.

possible causes of some of the disparity,[287] but many aspects of the pay gap remain unexplained. The type of work physicians do, either through formal specialization (or through focused practice), and the time spent by those providers can vary by gender.[288] By extension, OHIP Schedule can result in differing payments per unit of time, even for provision of the same or similar services.

455. The parties explicitly agreed to take steps necessary to achieve gender pay equity in Part D, paragraph 2 of the 2021-24 PSA. To this point, there have been approximately 14 submissions made to the PPC related to addressing the gender pay gap (note that some submissions involve multiple fee codes). Three examples include:

(a) New fee for pelvic exam with speculum. Various sections have suggested that this service is under-remunerated when billed using existing assessment codes. The creation of a new code for pelvic exams would help to ensure compensation is better aligned with the complexity and time associated with performing vital services for women's health.

(b) Alignment of surgical and procedural fee values for services related to male and female reproductive organs. Sections have proposed increasing the value of female genital procedures and surgeries to align with equivalent or similar procedures performed by urologists and general surgeons. OBGYN's are predominantly female, and urologists and general surgeons[289] are predominantly male; equating the fee values of this and other comparable services would improve equity.

(c) New time-based add on fee to assessment code. The Section on General and Family Practice ("SGFP") has proposed a time based add on fee to A007 for services exceeding 20 minutes in duration. Given the available

[287] Chami et al, 2023 *supra,* TAB 157 BOD VOL 7.
[288] Cohen & Kiran, 2020, *supra,* TAB 154 BOD VOL 7; Hedden L, Barer ML, Cardiff K, et al. The implications of the feminization of the primary care physician workforce on service supply: a systematic review. Hum Resource Health 2014;12:32, TAB 159 BOD VOL 7.
[289] Data Source: OMA, Physician Human Resources in Ontario, accessed April 30, 2024.

evidence that female physicians spend more time with patients per encounter, this can ensure that the additional time and associated care provided during a long patient encounter is more appropriately remunerated.

Appendix I sets out a list of existing submissions that could fall within the gender pay gap category.

III. New Services Resulting from Medical Innovation/Technological Advances

456. The parties explicitly agreed to take steps necessary to achieve gender pay equity in Part D, paragraph 2 of the 2021-24 PSA. Advances in medical innovation and technological advances continue with time; however, there has been no formal fee setting process since the 2008 PSA (2011 Funding Allocation) to update the OHIP Schedule to reflect these advancements. In this respect, the 2019 MSPC and 2022 PPC funding allocation timelines and amounts only allowed for the introduction of simple schedule revisions and fee adjustments.

457. As a result, there are many areas within the OHIP Schedule that have not evolved with the changing standards of practice and medical innovation meaning that the OHIP Schedule does not adequately or appropriately describe services that are now being rendered.

458. Physicians providing these evolved or new services that are not specifically or clearly listed in the OHIP Schedule have had to find other ways of being remunerated. This may include billing under existing umbrella fee codes or catch-all codes, submitting claims directly to OHIP medical consultants on an independent consideration (“IC”) basis (e.g., R990 and R993), billing the patient directly or securing payment from other sources such as academic funding for experimental programs (e.g., APPs, PET Steering Committee).

459. As well, certain diagnostic services listed in the OHIP Schedule and the Schedule of Facility Costs for Integrated Community Health Services Centre (“ICHSC”) have not been able to adapt to advances in medical innovation and technology due to the long-standing moratorium on changes to technical fees. Diagnostic services typically have separate technical and professional fees, where the technical fee is intended to cover the costs associated with the provision of the service. This is causing a backlog of issues that must be addressed, separate and apart from the OMA proposal to increase technical fees to reflect increasing costs that the payment of technical fees are intended to reimburse.

460. During past fee allocation processes, despite determining that technical fees were out of scope due to the technical fee moratorium, specialties still made submissions to the PPC and its predecessor the Medical Services Payment Committee (“MSPC”). Some examples that were brought forward during the Year 1 and 2 fee allocation process that would require establishing a new technical fee reflecting new medical innovations include:

- 3-dimensional modelling for medical use
- Ultrasound Elastography Evaluation of Liver
- Digital Breast Tomosynthesis
- Ultrasound - Biophysical Profile (BPP)
- Ambulatory EEG monitoring – with quantification of sleep
- Neuromuscular Ultrasound
- Transcranial Doppler Ultrasound – Complete/Limited Study
- Vestibular evoked myogenic potential (oVEMP and cVEMP)
- Video head impulse test ("vHIT)

461. There are approximately 33 submissions made to the PPC related to advances in medical innovation and technological advances. Three examples include:

- New fee for repetitive Transcranial Magnetic Stimulation (rTMS)

  Repetitive Transcranial Magnetic Stimulation treatment involves the stimulation of the prefrontal cortex with a varying magnetic field, which

induces an electric current following the principle of Faraday induction (which states that a rapidly changing magnetic field will induce an electric current in conductive material, with the current strength being proportional to the rate of change of the magnetic field). The application of this rapidly varying magnetic field, and resultant electric current, has been shown to be effective in the treatment of depression and other disorders.

- New fee code for Radiofrequency Ablation for Barrett's Esophagus

  Before the introduction of radiofrequency ablation (RFA) as a safe and effective therapeutic modality for the management of dysplastic Barrett's esophagus, patients with high-grade dysplasia or early cancer would undergo surgical resection of the esophagus. RFA is a minimally invasive treatment option that has been proven to be effective in randomized clinical trials in the management of dysplastic Barrett's esophagus.

- Revise fee code G390 (Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation) to include "First infusion of bispecific antibodies (such as glofitamab) Chemotherapy for infusion of CART cells".

  Cell based therapy, including Chimeric Antigen Receptor T cell (CAR-T) therapy and bispecifics, have led to a new era in the therapy of Malignant Hematology. These innovative approaches have yielded unprecedented improvements in the management of acute leukemias, lymphomas and plasma cell dyscrasias and have recently become an integral part therapy of patients in Canada.

462. To provide a further overview of the impact of technology and medical innovation, the OMA's submissions from its arbitration brief for the 2017-21 PSA to the Kaplan Board of Arbitration are attached as **Appendix II** to these submissions.

IV. Complexity of Patient Care

463. Complexity is one of the explicit factors forming part of the PPC's mandate under Part D of the 2021-24 PSA. Complexity of patient care can be influenced by the patient's age, co-morbidities, chronic health conditions, acuity of an episode (e.g., trauma) and type of medical/surgical intervention. More "complex" patient encounters tend to require additional time, have a higher level of acuity, and involve a greater level of intensity (e.g., knowledge, judgment, technical skill, risk and stress). Complexity of patient care is also discussed elsewhere in the brief in relation to family medicine. For the most part, payment under the OHIP Schedule has failed to explicitly address or explicitly recognize complexity.

464. In circumstances where physicians see more complex groups of patients, or risk/intensity varies considerably between cases additional modifiers are necessary to align the payments and the complexity of work performed. In addition, as patient demographics and standards of practice change the "average" complexity of a service will also increase and thus merit an adjustment to the fee.

465. There are approximately 47 submissions made to the PPC related to addressing complexity of patient care include. Three examples include:

- Fee increase to Lobectomy and segmentectomy fee codes (M143, M144 and M145). From the epidemiological point of view, early-stage lung cancer is observed more frequently in elderly patients. Thoracic surgeons are projected to operate on older and more frail patients as lung cancer screening becomes more prevalent. This leads to a larger fraction of patients requiring more dedicated care, increasing case complexity, increasing the length of surgery as well as length of post-surgical stay significantly. This increase in fees should reflect the increasing complexity of this surgical care.

- New psychiatry complexity modifiers. The Section on Psychiatry requested expanding the system already implemented in OHIP Schedule to provide

additional “Clinical Care Modifiers” that identify and recognize psychiatric services of higher complexity/intensity/risk. The current Clinical Care Modifiers, K187, K188 and K189, recognize periods of high risk and remunerate at a premium. K187 and K188 each provide the respective psychiatric services with a 15% premium, which is combinable to 30% if the conditions for both Clinical Care Modifiers are met. Psychiatry proposes expanding this system to include other markers of high complexity/intensity/risk.

- Revise payment rules to E682 (Pump bypass - graft of major vessel other than ascending aorta for the purpose of cardiopulmonary bypass or ventricular assist device) to be applicable with coronary artery repair and ventricular assist devices (fee codes R743 and R701-704). This is performed on complicated cardiac surgical patients who are unable to be accessed through traditional ascending aortic technique (e.g., axillary artery approach) where the bulk of the work is the dissection and isolation of the vessel and/or implantation of cardiac assist devices.

Appendix III contains a list of submissions identified as relating to complexity of patient care.

V. Fee Schedule Modernization

466. The parties explicitly committed to modernizing the OHIP schedule in Part D2 of the 2021-24 PSA which includes making changes to better reflect contemporary practice, and may include addition, revision and deletion of Schedule language and/or fee codes, having regard to such factors as time, intensity, complexity, risk, technical skills and communication skills required to provide each service.

467. As part of this process, codes may be deleted if they do not reflect current practice or are claimed for purposes other than which they are intended. New codes may be

introduced to better reflect the service being rendered or to better reflect current practice. Code descriptors may also be revised to reflect current practice.

468. Introducing new fee codes, while at the same time deleting outdated codes and/or revising existing codes to properly describe the service rendered, is expected to allow for appropriate claim submissions, improved monitoring and control, reduction in claim rejections and audits, and better tracking of the services provided.

469. There are approximately 178 submissions made to the PPC related to fee schedule modernization. Three examples include:

- Revise emergency department weekend and holiday visit fees to include Friday evenings. Many Emergency Department Alternate Funding Agreements (EDAFAs) count their Friday evening shifts as part of the weekend coverage for the purposes of shift equity as well as to calculate the base pay rate for shifts. In addition, other after-hours premiums currently already apply to Friday evenings (e.g., E409 and E410).
- Revise A020/A021 Complex dermatology assessment/consultation payment requirements to clarify applicable medical indications for billing these fee codes and to better capture language changes in the evolution in clinical practice and pathology seen by medical dermatologists.
- Unbundling of post-operative care from the surgical fee to allow pre- and post-operative care and visits to be billed. Currently in-hospital billings on a patient perioperatively (2 days preop and 14 days post op) are “bundled” into the surgical fee code, with the exception of visits for post-operative day 1 and 2 and for day of discharge (C124). With the advent of Enhanced Recovery After Surgery programs, “prehabilitation” for elderly patients, and significant changes in post-operative care of patients, average lengths of stays for “routine” surgery are significantly decreasing.

  Most elective surgical patients are admitted the day of surgery. As such, care provided for patients in hospital preoperatively, is almost always for emergency cases, where a decision to operate is made after admission, not

before. Patients admitted with emergent conditions that later may require surgery require ongoing care and management that is outside the “routine” of preoperative care. These patients are not admitted to “optimize” them for an elective operation. They are often sick and require significant care and are not all planned to go to the operating room.

With current perioperative care plans, and significant changes in perioperative care, any patient in hospital longer than 7 days requires active care and should not be included in the “routine” postoperative care that is bundled into the surgical fee.

Appendix IV sets out a list of submissions that falls within the category of schedule modernization.

C. FAMILY MEDICINE

I. Introduction

470. With millions of unattached patients, Ontario is in the midst of an unprecedented family medicine crisis. Family physicians have long been struggling to hold a broken system together, but as the role of the comprehensive longitudinal family physician has become increasingly devalued and eroded, leading to inevitable demoralization, they are no longer able to do so without additional funding and support.

471. The existence and extent of the crisis facing family medicine is everywhere, as reflected and summarized by the CPSO in its official publication[290], including the fact that:

a) as of 2022 2.2 million Ontarians (15% of the population) do not have a family doctor (up from 1.8 million just three years earlier);

b) that family doctors are under strain too as they grapple with increasing clinical and administrative demand with the National Physician Health Survey from the Canadian Medical Association (CMA) reporting that more than 1 in 2 physicians

[290] Foxman, *supra,* TAB 8 BOD VOL 1.

and residents report high levels of burnout with the prevalence is significantly higher among those in general practice/family medicine;

c) nearly 15% of Ontarians (1.7 million people) who currently have a comprehensive family practitioner may lose them to retirement by 2025;

d) family doctors who are over 65 are seeing increasing numbers of patients who are also over 65 and who need more medical resources and make more primary care visits so that expected retirements may leave in limbo a patient group that has especially high needs;

e) every year of the last decade has seen a lower percentage of medical learners choosing family medicine while at the same time even among graduating family doctors with only 15% are choosing to set up a comprehensive family care practice;

f) the proportion of family doctors who are comprehensive practitioners is declining (from 77.2% in 2008 to 70.7% in 2019), with more and more doctors are shifting into more focused scopes of practice, like palliative care or sports medicine across all career stages;

g) practice demands are changing, with complexity of work exploding, the aging population, the rise of chronic diseases and the expansion of clinical practice guidelines;

h) these care needs are coupled with a huge increase in administration, with OCFP noting that family doctors face administrative burdens that can take up to 19 hours a week, and the CMA reporting that family physicians work an average of 52 hours per week but only spend 36 hours caring for patients taking away from direct patient care or eating into off-hours;

i) the fragmented health care system is filled with bottlenecks, making it increasingly difficult for family doctors to get patients the diagnostic tests and other supports they need; and

j) this clinical and administrative burden weighs heavily on practitioners, leading some doctors to cut back, so that family physicians aren't taking on the patient load they used to.

472. Moreover, since 2008, Ontario's health spending per capita has consistently ranked at or near the lowest in Canada.[291] The chronic underfunding of family medicine has resulted in Canadians having the worst access to primary care among all OECD countries, according to a 2023 Commonwealth Fund and is undoubtedly contributing to the current crisis.[292]

473. This crisis has been years in the making and is the result of a multitude of intersecting and interrelated factors including the increasing complexity of patients requiring more physician time per visit, more indirect patient care, a significant increase in the administrative burden on physicians, rising costs for their staff and offices, and the impact of the pandemic. As the COVID Science Advisory Table reported, "primary care is facing an accelerating capacity crisis driven by limited HHR, varying models of care delivery, and an information and communication infrastructure that is inadequate to support the coordination of care and the integration of primary care with other health (including public health) and social services" together with "the growing and aging population, changing physician demographics, impending retirements, shifts away from comprehensive family practice, and burnout across PCC [primary care clinician} professions"[293] All of this has led to a decline on the part of both new and established

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[291] Financial Accountability Office, *2022-23 Interprovincial Budget Comparison* (April 10, 2024) at p. 1 [FAO Interprovincial Comparison], TAB 78 BOD VOL 3.
[292] CIHI, "Primary health care: International survey shows Canada lags behind peer countries in access to primary health care" (March 21, 2024), TAB 160 BOD VOL 7.
[293] Dee Mangin et al., "Brief on Primary Care Part 2: Factors Affecting Primary Care Capacity in Ontario for Pandemic Response and Recovery," Ontario COVID-19 Science Advisory Table, at p. 2, [COVID Science Table Report 2] TAB 161 BOD VOL 7.

physicians in practicing comprehensive longitudinal care, and corresponding declining attachment rates, as "shifting physician demographics, impending retirements, shifts away from comprehensive family practice, limited service provision by some PCCs during the pandemic and burnout across PCCs pose an accelerating threat to the provision of primary care in Ontario."[294]

474. The Science Table also emphasized the extent to which "an increasing proportion of Ontario family physicians in every age group and at every career stage is shifting away from comprehensive practice and into focused scopes of practice (such as emergency medicine, sports medicine, palliative care, and more)." However, while "Comprehensive care is the type of primary care that is most strongly associated with better health outcomes and lower health system costs," as a result of shifts away from comprehensiveness, the overall proportion of Ontario family physicians providing this type of care has dropped from 77.2% in 2008 to 70.7% in 2019." At the same time, "further exacerbating these challenges is the declining proportion of graduating medical students ranking family medicine as their first choice of specialty when applying to residency."[295] Of course, the rising number of unattached patients has also been exacerbated by the unprecedented growth of the population over the last few years.

475. As the COVID Science Table also found, the pandemic has had an ongoing impact of the practice of family medicine:

> "During the COVID-19 pandemic, some preventive and ongoing services have been deferred or delayed. This has led to people presenting to primary care later, with multiple acute and chronic concerns, a high level of mental health comorbidity substance use, and worsening of major mental illness. Navigation of our complex health system, often coordinated by PCCs, is needed for patients who require tests, procedures, and specialist consultation, which in turn have become more difficult to access. While patients await access to or are discharged from more specialized care, the management of increasingly complex care needs falls largely to PCCs. This increases stress among primary care patients and their PCCs, adds to

[294] *Ibid.* at pp. 1-2, TAB 161 BOD VOL 7.
[295] *Ibid.* at p. 4, TAB 161 BOD VOL 7.

> workload and the complexity of that workload, and erodes primary care capacity and, in turn, access to care for all patients."[296]

476. In the OMA's submission, the parties have a collective obligation to fix a broken family medicine system in crisis, so that physicians are supported and encouraged to provide comprehensive family medicine care for Ontarians and Ontarians can get the care they need and deserve. As discussed below, the OMA's targeted proposals for family medicine are aimed at beginning to rebuild comprehensive longitudinal family medicine as a desirable and competitive profession.

II. Unattached Patients

477. As noted above, evidence of the current family medicine crisis is starkly apparent in the millions of Ontarians currently lacking a family doctor. As detailed elsewhere in this brief, there are 2.3 million unattached patients, and the problem is only getting worse every day, with forecasts of an additional 60,000 patients becoming unattached every month. By 2026, forecasts estimate that the number of unattached patients will reach 4 million, or more than one in four Ontarians.[297]

478. Attachment to a family physician is key to a healthier population overall with fewer demands on the health care system. As has been repeatedly found in the academic literature, "[c]ontinuity of care with a primary care professional or team is associated with improved access, better preventive care, decreased utilization, decreased health care costs, improved health, decreased mortality, and improved patient satisfaction."[298]

479. Of further concern is the fact that "those not formally attached were more likely to be low-income, urban, and new immigrants, and have complex needs that may be better met with the support of interdisciplinary teams."[299] For example, studies have shown that "a lower proportion of new immigrants are attached to a [primary care provider] compared to those who are not new immigrants (77.5% vs 88.2%), fewer Ontarians in the lowest

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[296] *Ibid.* at p. 3, TAB 161 BOD VOL 7.
[297] OCFP, "More Than Four Million Ontarians Will Be Without a Family Doctor by 2026," (November 7, 2023) Tab 162 BOD. VOL 7.
[298] COVID Science Table Report 2, *supra,* at p. 6, TAB 161 BOD VOL 7.
[299] *Ibid.* at p. 14.

income quintile are attached compared to those in the highest (83.9% vs 89.9%), and fewer with the highest degree of family or housing instability (residential instability) are attached compared to those with the lowest level of residential instability (83.8% vs. 90.3%)."[300] The growing numbers of unattached patients is a problem in need of urgent solutions.

III. Increasing Complexity

480. As also noted above, one key factor underlying the crisis is the increasing complexity of patients who are presenting sicker and who therefore require longer appointments with their family physicians.

481. Increasing complexity is, in part, a product of the pandemic where some preventive and ongoing services were deferred or delayed and resulting in patients later coming to their family doctors with "multiple acute and chronic concerns, a high level of mental health comorbidity, substance use, and worsening of major mental illness."[301]

482. Increasing complexity is also the result of an aging population. Studies have shown that people "aged 80 years and older are being treated for over 50% more conditions and have experienced the largest increases in prescription drugs dispensed, lab tests, imaging and specialist visits"[302] As well, "[d]ay surgeries, prescriptions, lab tests and surgical specialist visits increased among people aged 40 years and older, which is also the fastest growing age group within the population."[303]

483. As well, a greater number of patients, who previously would have had access to institutional care, must now be maintained and cared for in the community due to acute care hospitals being over capacity, a lack of long-term care beds, and the closure of mental health hospitals without ensuring a corresponding increased community capacity.

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[300] *Ibid.* at p. 7.
[301] *Ibid.* at p. 3.
[302] Ruth Lavergne et al., "Examining Factors That Shape Changing Workloads in Primary Care Groups," Healthcare Policy Vol.19 No.1, 2023 [123] at p. 124, TAB 163 BOD VOL 7.
[303] *Ibid.*

484. Increasing complexity in turn has a significant impact on the amount of time a physician must spend on both direct and indirect patient care. There are multiple issues to be addressed at each visit, with physicians having to spend increased time with patients during visits. In addition, there is ongoing and increasing unpaid time required to complete various forms, to arrange for more specialist referrals and related follow up. This includes increased time spent sending the same referral to multiple specialists due to their backlogs and waitlists, and to deal with the myriad of other tasks involved in patient follow-up in navigating other parts of the health care and social services system). As discussed further below, delays in accessing specialist care means that a family physician must in the meantime continue to provide care to those patients, who in reality need specialist care. At the same time, the additional work in ordering tests and navigating referrals increases the ever-growing administrative burden.

485. One patient visit can lead to a significant volume of indirect patient care which is unpaid, including referrals and follow up with specialists, labs and diagnostics to review, insurance or other forms to be completed, and phone calls and emails back to the patient. The majority of these activities will not be reflected in billing data, and nor are they otherwise compensated. The unpaid and unbilled nature of these activities also means they are not measured or counted as work performed, contributing to the Ministry's accusation that family doctors are not working hard when in fact they are doing huge amounts of additional and invisible work.

486. Insufficient publicly funded community resources have also left family physicians in the role of patient navigator/care coordinator, taking valuable time away from their ability to provide direct clinical services. With the recent significant increase in immigration to Ontario, new immigrants often face significant barriers in accessing health-related services. This includes community support services, educational services, mental health services, other allied health supports among others. The high needs of these populations, coupled with the lack of publicly funded supports, results in family physicians often needing to act as navigators, trying to find their patients the services they require and,

when such services are not available, extending their role/capacity to support these patients.

487. Increasing clinical care guidelines applicable to the care of patients with complex conditions also consume significant physician time and resources. According to one study, it would take 26.7 hours per day (14.1 h/day for preventive care, 7.2 h/day for chronic disease care, 2.2h/day for acute care and 3.2h/day for documentation and inbox management) for a family doctor to provide guideline-based care to a roster of 2,500 patients in 2020. Providing ideal guideline-based preventive, chronic disease, and acute care services places a growing and significant time burden on a family doctor that is only partially mitigated by team-based care models and smaller panel sizes.[304] This study points to the need to find ways of shifting tasks that do not require a physician's medical expertise to other team members, thereby enabling physicians to focus on core clinical tasks. However, to this point, despite multiple announcements, family physicians have not been provided with the funding support they need to hire additional team members.

IV. Increasing Administrative Burden

488. As also noted above, a further significant contributor to the current crisis in family medicine is the increasing administrative burden that family physicians face. As the health care system has evolved, it has shifted more care and coordination of care, to family physicians in community-based care. As a result, family physicians are spending more time on indirect patient care and less clinical time with patients. A major component of indirect patient care is the increasing administrative burden. It is also important to underline that, for Ontario physicians, time spent performing administrative tasks is not directly compensated.

489. One task contributing to the administrative load is specialists' referrals. In Ontario, there is no centralized referral system which has significant implications. Family physicians spend a great deal of time finding a specialist that will see their patient and,

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[304] Porter J, Boyd C, Skandari MR, Laiteerapong N. "Revisiting the Time Needed to Provide Adult Primary Care". J Gen Intern Med. 2023 Jan;38(1):147-155. doi: 10.1007/s11606-022-07707-x. Epub 2022 Jul 1. PMID: 35776372; PMCID: PMC9848034, TAB 164 BOD VOL 7.

while waiting for a specialist appointment, they must provide care to monitor and follow up the patient to, at least, keep their condition stable. Family physicians also spend significant time figuring out which specialist within a given specialty to send a referral to. This responsibility has become more complicated and time consuming in recent years as wait times for specialty services have increased, and health human resource challenges impacting specialists have gotten worse. As specialists have very long wait lists, they regularly reject referrals causing family physicians to spend an inordinate amount of time in a coordination role trying to find specialists willing to treat their patient (e.g. a physician may have to try 5 or more specialists before a referral is accepted). In addition, family physicians are responsible for explaining the delays and complexities of the system to their patients, at the same time as they are networking and connecting with colleagues to try to find workarounds to mitigate the issues and expedite the referrals as much as possible.

490. Along with specialist referrals, the administrative time spent completing forms has increased. As the complexity of patient needs increases, family doctors must increasingly prepare a plethora of forms and letters, including not only sick notes but also public health forms, exceptional access program forms, Children's Aid Society forms, WheelTrans application forms, parking permits, lengthy government disability forms from both the federal government and insurers, amongst countless others. Often these forms are needed to provide access to services for vulnerable patient populations.

491. The increased digitization of health care has exacerbated the issue as it has made it easier for patients and others to email or fax the forms for completion, not to mention the extent to which different referral sites require special referral forms and portals in order to refer a patient which make the process of referral much longer and complicated. The transfer of patient records from hospitals has also resulted in physicians having to review a large number of records in Hospital Report Manager, even where they do not need to take action.

492. The ongoing expansion of scope of practice for other regulated health professionals has also increased the administrative burden for family physicians. For

example, as discussed above, enabling pharmacists to prescribe for minor ailments has resulted in physicians receiving hundreds of Minor Ailments reports and Medscheck reports. The impact that this change on family physicians has been significant, as they are required to review and evaluate the information in these forms and incorporate them into the patient's medical record where relevant and appropriate.

493. As studies have shown, generally there is a "substantially increased coordination workload per FP visit."[305] As well, "electronic medical records (EMRs) are associated with increased patient care quality and safety, but they have also added data entry tasks for clinicians and increased time spent on indirect patient care."[306] In addition, at the end of a busy day seeing patients in their clinic, family doctors are expected to answer all the patients' queries received in their inboxes, again a task for which they receive no compensation.

494. The Canadian Medical Association's 2021 survey also found "family physicians are disproportionately negatively impacted by administrative burdens, with nearly half (45%) of all family physicians surveyed in 2021, spending, on average, 10-19 hours per week on administrative tasks (i.e., between one and two full workdays).[307] Clearly, this increasing administrative burden is also a direct cause of burnout and of family physicians choosing to leave comprehensive family practice.

495. One such physician is Dr. Fan-Wah Mang, a 53-year-old family doctor who has recently announced that she is shutting down her Mississauga practice after more than 20 years as a result of rising costs and administrative burden. Her story tells an important and cautionary tale about the urgent need to address the problem of administrative burden:[308]

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[305] Lavergne, *supra* at p. 115, Tab 163 BOD VOL 7. See also Joanna Willms, "Mission: Don't Burn Out. An expanding QI Project." (Oct 11, 2023), TAB 165 BOD VOL 7. In this case study, examining the growing burden of indirect patient care, it was reported that upwards of 70% of one family physician's time is spent on indirect patient care.
[306] Lavergne, *supra* at p. 124, TAB 163 BOD VOL 7.
[307] COVID Science Table Report 2, *supra,* at p. 5, TAB 161 BOD VOL 7.
[308] *Toronto Life, supra* TAB 26 BOD VOL 1.

> By July of 2023, I had to go from seeing patients four days a week to seeing them three days a week, just so I could dedicate one entire workday to paperwork. That also meant I was cutting out one full day of income each week—after all, I get paid only when I'm seeing patients...
> But, when messages from my patients started piling up, I couldn't turn them down. With my reduced hours, the next available appointment would often be weeks away...I ended up calling them on my "off days" or seeing them in-person during my lunch hour and in the evenings.
> Burnout started to creep up on me... By September, it was all too much... I wasn't going to wait until I was so exhausted that I became sick myself... Just like that, it was settled: the business was going to fold.
>
> The guilt was terrible...Many of my patients are women between 85 and 90 years old. I remember one crying, silently, behind her medical mask. I held her hand as she told me how terrified she was that no other practice would take her—that they'd see her as too old or her issues as too complex...
>
> Rising costs, inflation and the burden of all this new administrative work has made running a family clinic untenable....The fees doctors get paid for seeing patients needs to double, at the very least. With that money, family doctors would be able to hire the staff they need to sustain their practices, like more nurses. At the same time, we should be paid for the administrative work we do, a policy that's already been implemented in BC. And the government needs to find a way to reduce that administrative burden...
>
> I love being a family doctor. I want to protect our public health care system because it has worked for my patients. But it's getting impossible to care for them with expenses skyrocketing, income declining and only so many hours in a day. Family doctors are not trying to get rich. We just want to earn enough to keep the lights on and allow us to protect our patients.

496. While this is just one doctor's story it is emblematic of the problems that family physicians are facing throughout the province. Of course, for every doctor that makes a choice like Dr. Mang's, potentially thousands of patients will join the ranks of the unattached.

V. The Impact of the Pandemic

497. As indicated above, a further factor contributing to the current crisis in family medicine is the ongoing impact of the COVID-19 pandemic. As reported by the COVID-19 Science Advisory Table, during the pandemic "beyond ongoing primary care services for their patients, family physicians have taken on multiple roles, including managing

infections in the office and through remote care; supporting public health (e.g., by staffing assessment and vaccination centres); providing surge capacity in acute care settings; and supporting outreach to equity-deserving populations."[309] In addition, in rural communities, there was "extraordinary pressure to keep emergency departments (EDs) open...Many rural family physicians [were] asked to prioritize the ED and forego their offices to keep EDs open, further impacting workload and primary care delivery in many rural settings."[310]

498. Together with the countless and tireless contributions made by family physicians during the pandemic, the Advisory Table also reports as follows:

> During the COVID-19 pandemic, preventive and ongoing care have been deferred and delayed for multiple reasons, causing patients to present later to primary care with greater acuity and complexity. Managing these increasingly complex care needs falls on primary care clinicians (PCCs) as increasing wait times for tests, procedures, and specialized care further contribute to the erosion of primary care capacity. COVID-19 has added stress to a system already experiencing considerable strain, with longstanding pressures and intersecting factors undermining the quality of primary care in Ontario.[311]

499. In other words, the pandemic has cracked open the fault lines in the already fractured system that is family medicine in Ontario. The COVID-19 pandemic saw thousands of surgeries and appointments cancelled or delayed, creating large backlogs and the requirement that family doctors provide ongoing and more complex care to their patients experienced delayed access to necessary procedures.

VI. Physician Burnout

500. As defined by the World Health Organization, burnout is "chronic workplace stress that has not been successfully managed." It is characterized by emotional exhaustion, depersonalisation and a reduced sense of personal accomplishment. For physicians, burnout is associated with depression, suicidal ideation, substance use, motor vehicle

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[309] COVID Science Table Report 2, *supra,* at p. 5, TAB 161 BOD VOL 7.
[310] *Ibid*.
[311] *Ibid*. at p. 1.

crashes, reduced productivity, increased turnover and early retirement and has "also been associated with poor patient outcomes, including lower quality of care and increased medical error."[312]

501. Troublingly, all of the factors discussed above are also resulting in increased pressure on family physicians who are experiencing burnout. In fact, it has been reported that "the rate of burnout among family physicians tripled in 2021 compared with the previous year, with 51% of family physicians indicating they were working beyond capacity."[313]

VII. Shortage of Family Physicians in Ontario

502. As discussed elsewhere in this brief and as a result of all of these factors, Ontario is now facing a shortage of family physicians, and particularly of family physicians providing comprehensive longitudinal care. Ontario has one of the lowest number of family physicians per capita, and an increasingly significantly smaller proportion continue to provide comprehensive longitudinal care. As well, fewer new physicians are choosing to practice comprehensive family medicine at the same time as more family physicians are leaving practice, all of this as a growing and aging population requires even greater numbers of family physicians.

503. As Ontario's physician workforce ages, "an increasing proportion of comprehensive [family physician] workforce was near retirement age" and "[c]orrespondingly, an increasing proportion of patients were attached to near-retirement comprehensive [family physicians]."[314] Between 2008 and 2009, the proportion of Ontarians attached to a family physician aged 65 years or older has doubled, which means "1.7 million Ontarians may lose their family physician to retirement by 2025," a

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[312] Gajjar, *supra,* TAB 34 BOD VOL 1.
[313] COVID Science Table Report 2, *supra,* at p. 5, TAB 161 BOD VOL 7.
[314] Kamila Premji, Michael E Green, Richard H Glazier, Shahriar Khan, Susan E Schultz, Maria Mathews, Steve Nastos, Eliot Frymire, Bridget L Ryan, "Trends in patient attachment to an aging primary care workforce: a population-based serial cross-sectional study in Ontario, Canada" medRxiv 2023.01.19.23284729; doi: https://doi.org/10.1101/2023.01.19.23284729 at p. 9, TAB 166 BOD VOL 7.

number which is likely an underestimate in light of the fact that family physicians are now retiring earlier than previously.[315]

504. In addition, fewer graduating medical students are ranking family medicine as their first choice of specialty when applying to residency,[316] causing medical school leaders to raise the alarm. Recently, respected senior officials from four Ontario medical schools called for "significant reforms, including raising pay and reducing administrative burdens [in order] to persuade the physicians of tomorrow to choose family medicine over higher-paid specialties," noting that the problem was "urgent."[317]

505. The statistics confirm that graduating medical students are no longer choosing family medicine as their first choice. In 2024, in the first-round selection process, 108 of 560 family medicine residency slots in Ontario went unfilled, up from 100 last year, 61 in 2022, 52 in 2021 and 30 in 2020.[318] While ultimately the available family medicine spots were filled in Ontario this year in the second round of the match, this is because residents who did not choose family medicine in the first round of the match have no choice but to match to remaining available family medicine residency positions if they are to complete their training and become independently licensed physicians.

506. As the following chart illustrates, the interest among medical school graduates in family medicine is the lowest in 15 years.[319]

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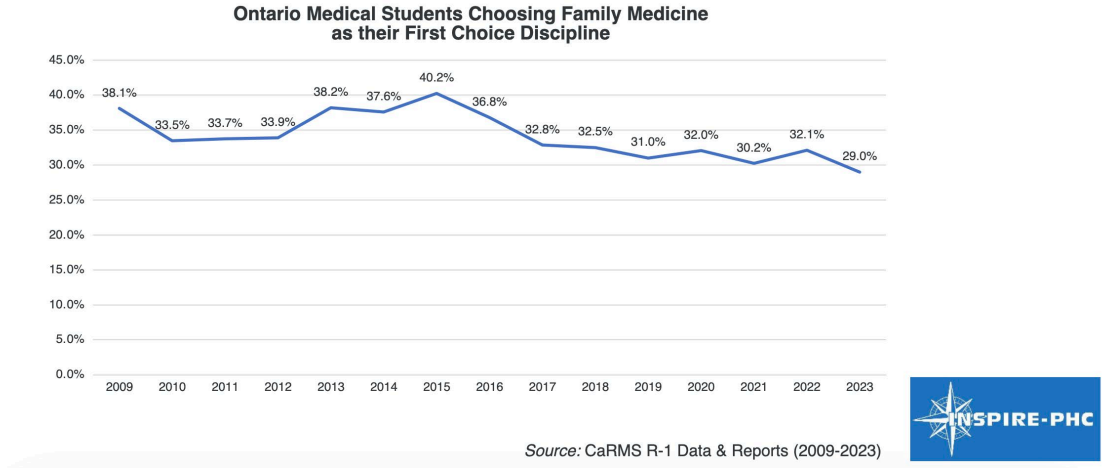
[315] *Ibid*. at p.4.
[316] COVID Science Table Report 2, *supra,* at p. 4, TAB 161 BOD VOL 7.
[317] Kelly Grant, "Medical schools raise alarm over declining interest in family medicine" *Globe and Mail,* (April 23, 2024), TAB 167 BOD VOL 7.
[318] *Ibid.*
[319] Premji K, Green ME, Glazier RH, Khan S, Schultz SE, Mathews M, Nastos S, Frymire E, Ryan BL. (2023), INSPIRE-PHC Data Charts, October 2023, ["INSPIRE-PHC DATA"] TAB 168 BOD VOL 8.

Declining Interest Among Medical School Graduates in Family Medicine

- Lowest in 15 years



507. As well, as discussed above, the practice of comprehensive longitudinal family medicine is on the decline. Comprehensive longitudinal family practice is "the provision of a broad range of services on a longitudinal basis to a defined panel of patients of all ages, backgrounds, and health conditions."[320] The true value of primary care is realized through a continuous relationship between a patient and their family physician, coordination of care, being the first point of contact in the health system, and the comprehensiveness of services.[321] Despite the fact that comprehensive longitudinal care is associated with better health outcomes, the overall proportion of Ontario family physicians providing this type of care has dropped from 77.2% in 2008 to 70.7% in 2019 to 65.1% in 2022.[322]

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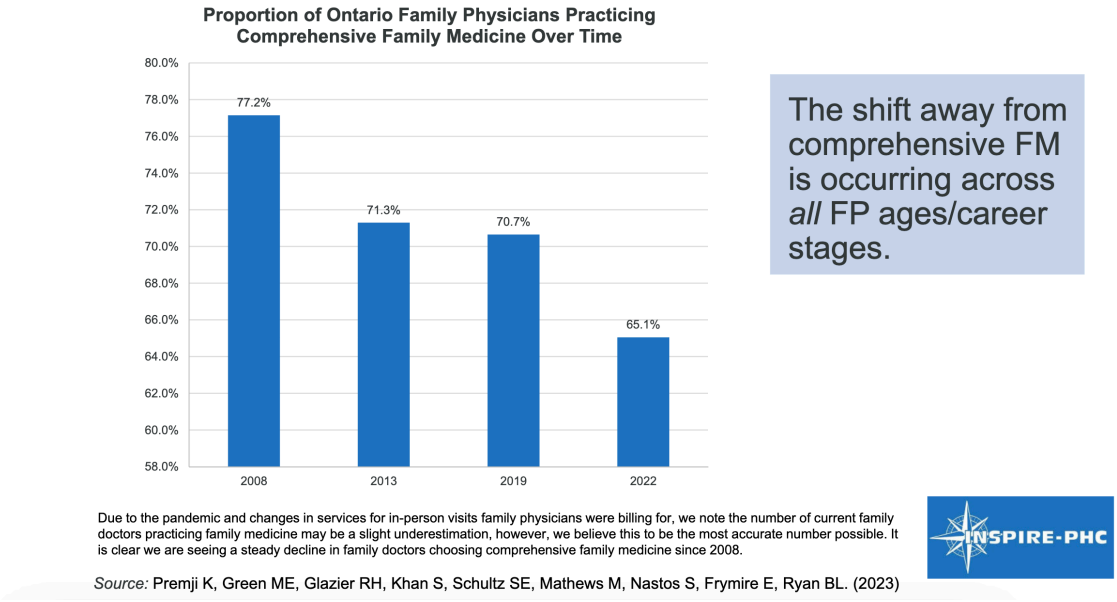
[320] COVID Science Table Report 2, *supra,* at p. 4, TAB 161 BOD VOL 7.
[321] Starfield, B., Shi, L. and Macinko, J. (2005), Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, 83: 457-502. https://doi.org/10.1111/j.1468-0009.2005.00409.x, TAB 169 BOD VOL 8.
[322] COVID Science Table Report 2, *supra,* at p. 4, TAB 161 BOD VOL 7; See also INSPIRE-PHC DATA, *supra,* at p. 2, TAB 168 BOD VOL 8.

Declining Practice of Comprehensiveness



508. As noted, at the same time as the interest in family medicine is declining amongst practitioners and retirements are increasing, the population is also growing[323] and aging. As well, the diversity of patients served and the complexity of their needs grows, along with rapidly evolving technology, the practice of family medicine has become much more challenging.

509. The OMA's proposals are aimed addressing these challenges by making the practice of family medicine more desirable.

VIII. Increasing Costs of Practice

510. It goes without saying that family physicians are also facing increasing costs of practice, reinforced by the inflationary increases to physician expenses over the past several years. These costs include ongoing costs for staff, office space, equipment, supplies, along with new costs related to IT (online appointment booking, cyber insurance,

[323] Government of Ontario, "Ontario Population Projections," Accessed April 18,2024, TAB 170 BOD VOL 8.

EMR, Cloud Storage, Cloud word processing). As physicians are health information custodians, they must be rigorous in their security and storage protocols.

511. Unlike other small businesses however, a family physician cannot pass along the growing impact of inflation and increasing costs of goods and services to the consumer through higher prices. As a result, many family physicians have reported that the cost of running a practice results in an increasingly unsustainable business model.

512. We are now at a critical stage where it is vital to increase compensation for existing family physicians to help them to offset inflation and the growth in their overhead, to recognize the increasing administrative burden, and to incentivize and make it possible for them to take on more patients where it is possible to do so without compromising access. These improvements are also critical to encourage new graduates to choose to practice comprehensive family medicine.

513. In order to address and arrest the crisis in family medicine, and in addition to the bare minimum of inflationary increases across all family physician models, family physicians must receive increased compensation for their total time/service providing patient care, in order to reflect all of the growing workload and other pressures that comprehensive family physicians face. Moreover, as set out in a separate OMA proposal (see section N below), in order to encourage and support team-based care, the OHIP Schedule should be amended to allow physician to bill for duties delegated to other health professionals including RNs and NPs. Providing increased compensation directly to family physicians will allow them to build their own primary care teams that can meet the needs of patients and grow the number of patients that can be attached.

514. As discussed below, the OMA's proposals are aimed at addressing these goals.

IX. Family Medicine Compensation Improvements in Other Provinces

515. Before turning to the OMA's specific proposal to improve compensation for family physicians, it is critical to recognize the extent to which the challenges facing the practice of family medicine are not unique to Ontario but can be seen in other provinces as well.

However, in these other provinces, additional compensation measures, which recognize the need to recruit and retain family physicians, have been implemented with a view to improving both recruitment and retention, and to addressing the family medicine crisis. While the Ministry has indicated that on its analysis, average compensation for family physicians in Ontario remains higher than in other provinces (to which the OMA will reply as appropriate), the overwhelming reality is that in these other provinces, governments have uniformly recognized that in order to respond to the growing and widespread crisis in family medicine, it is critical to improve both the structure and level of compensation for family physicians.

516. Over the last 24 months, five provinces have announced significant family medicine reforms and investment to help address the crisis facing their province. A high-level comparison chart of the various models is below. A much more detailed comparative chart can be found at **Appendix V**.

	ON FHO	**BC LFP**	**MAN FM+**	**NS LFM**	**NFLD**	**SASK TPM**
Main Source of Income	Capitation	Hourly Sessional	FFS	Capitation & Hourly	Capitation	FFS
Shadow Billing	19.4%	N/A	N/A	30%	25%	N/A
Hourly Rate	N/A	$130/h	$171.05/h Max 0.5h / 250 pats / week	$92.70/h day $139.05/h night	N/A	N/A
Capitation Rate	$200/pat adj	$34/pat adj	$75/pat adj	$103/pat adj	$180/pat adj	Max $144K
Negation	Yes	No	No	No	No	No
Admin / Overhead	No	Yes – hourly rate	Yes - $3.50 per visit	Yes - $20 per pat	Yes – Startup funding, EMR	Yes – CME, innovation
Date	Feb 2007	Feb 2023	Apr 2024	Oct 2023	Apr 2023	Apr 2024
Estimated Compensation Increase		**54%**	**21.5%**	**28.3%**	**34.6%**	**43.4%**

517. Alberta, not listed above, has now struck a separate memorandum of understanding to address family medicine and has begun stabilization funding.

518. As these examples demonstrate, other provinces are showing a commitment and investment of significant compensation increases and measures which address the varied services that family physicians are providing, in order to address the crisis in family medicine and to help recruit, retain and support family doctors.

519. In this respect, many provinces have recognized the indirect physician clinical time being spent, and are compensating for it through such mechanisms as providing hourly rates for indirect clinical work, overhead funding and EMR funding.

a) British Columbia (LFP)

520. The Longitudinal Family Physician (“LFP”) Payment Model was developed by the BC Ministry of Health in negotiations with BC Family Doctors and Doctors of BC. An alternative to the fee-for-service model, the LFP payment model is a blended model to support physicians in family practice who provide longitudinal family medicine care. It was developed to:

- Recognize the complexity of longitudinal care
- Value the time spent with patients
- Resource family medicine clinics as critical health care infrastructure
- Acknowledge the value of indirect care and clinical administrative services
- Support physician agency and flexibility in practice.

521. The LFP Payment Model is a blended payment model which compensates a physician for:

(a) physician time;
(b) physician-patient interactions; and

(c) the size and complexity of a physician's patient panel.[324]

522. In the first twelve months since its launch, 4,000 family doctors had enrolled in the LFP model, more than 500 of whom are new to practice or newly billing Medical Services Plan ("MSP"), and including many others who were poised to close their offices and who are now choosing to continue practicing.[325]

523. It is expected that, under this new framework, family medicine physicians will see a 54% increase in income, with a recognition of their administrative time and reduced administrative burden.[326]

524. Funding within the BC LFP is simplified. There are three types of hourly rates, all paying the same rate:

1)	Direct Patient Care	$32.50/15 minutes
2)	Indirect Patient Care	$32.50/15 minutes
3)	Clinical Administrative Time	$32.50/15 minutes

525. Clinical Administrative Time is limited to a maximum of 10% of annual hourly earnings.

526. In addition to the hourly rate, physicians can bill for patient interaction using one of 8 billing codes. These billing codes range from $25 - $110. It is noteworthy that a virtual visit pays the same as an in-person visit.

527. The other key component of the model is the recognition of maintaining a roster (or panel) of patients. Once the Provincial Attachment System is fully established for identifying physicians' Empanelled Patients, the panel payment will be calculated based

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[324] Doctors of BC, "Longitudinal Family Physician Payment Model,", TAB 171 BOD VOL 8.
[325] Doctors of BC, "Celebrating the one-year anniversary of the Longitudinal Family Physician Payment Model", *supra,* TAB 146 BOD.
[326] CBC News, "B.C. launches new payment model for family doctors" (February 1, 2023), TAB 172 BOD VOL 8.

on the number of Empanelled Patients and the complexity of those patients. It is currently estimated that the average payment will be $34 per patient.[327]

b) Manitoba (FM+)

528. Manitoba's Family Medicine Plus, or FM+, launches April 1, 2024. In response to serious concerns from family physicians, Doctors Manitoba negotiated a new remuneration model for longitudinal family practice that complements traditional volume-based fee-for-service revenue with more stable, predictable non-volume forms of revenue. FM+ was developed with extensive feedback from family physicians, informed by evolving payment models being developed in other provinces.

529. Unlike models in other provinces where fee-for-service remuneration is reduced by as much as 70%, family physicians in Manitoba will have access to all the existing tariffs at 100% plus new panel payments and remuneration for indirect clinical time. This will help to stabilize clinic operations, help physicians spend more time with their patients, and help more patients connect with a family physician.[328]

530. There are three broad components under FM+ for family physician remuneration and funding:

- Volume-based: existing fee-for-service payments for visits and procedures.
- Panel-based: quarterly funding based on the size, age and complexity of your patient panel.
- Indirect clinic time: weekly payments to recognize up to three hours of indirect clinical services.

531. Together, the investment in this model is expected to result in at least a 21.5% increase in compensation for this year, and a 30% increase by 2026.

532. Significant improvements on the fee structure include:

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[327] Government of British Columbia, Ministry of Health Medical Services Commission Longitudinal Family Physician Payment Schedule, March 11, 2024, TAB 173 BOD VOL 8.
[328] Doctors Manitoba, "FM+ Remuneration Overview" (March 20, 2024), TAB 174 BOD VOL 8.

1) Virtual care being paid at 100% the value of in-person care[329]
2) A new "Extended Visit" fee at $70 for two or more issues[330]
3) A new overhead fee to recognize the escalating clinic costs that can be associated with in-person visits in a community setting. An additional $3.50 per visit (up to a maximum 50 per day) can be claimed in addition to an office/home visit.[331]
4) New collaboration fees with other providers, between $16-$25.[332]

533. A new panel payment for the FM+ model has three components:

1) Patient Age
2) Chronic Disease Care
3) Mental Health Care

534. The average panel payment is expected to be $75 per patient.[333]

535. In addition to new panel payments, Manitoba Health is encouraging family physicians to enroll newborns and infants into the panel. Under FM+, a newborn and infant enrollment payment has been created to recognize the additional and detailed work involved with assuming care for a patient under the age of two. There is a new $100 fee for accepting newborn and infants into practice.[334]

536. Manitoba also now remunerates indirect clinical services for up to three hours per week. Physicians receive up to 30 minutes per week for every 250 patients enrolled in their panel, payable at $171.04 per hour and billable in 15 minute increments.[335]

c) Nova Scotia (LFM)

537. The Longitudinal Family Medicine payment model was designed to strengthen family medicine in Nova Scotia. It aims to provide stable, equitable funding for physicians

[329] Doctors Manitoba, "Virtual Visit Tariffs" (February 9, 2024), TAB 175 BOD VOL 8.
[330] Doctors Manitoba, "Extended Visit" (September 28, 2023), TAB 176 BOD VOL 8.
[331] Doctors Manitoba, "Community-Based Practice Supplement" (September 28, 2023), TAB 177 BOD VOL 8.
[332] Doctors Manitoba, "Communication Between Providers" (January 18, 2024), TAB 178 BOD VOL 8.
[333] Doctors Manitoba, "FM+ Panel Payment Billing Guide" (March 7, 2024), TAB 179 BOD VOL 8.
[334] Doctors Manitoba, "Newborn Enrollment" (March 11, 2024), TAB 180 BOD VOL 8.
[335] Doctors Manitoba, "Indirect Clinical Services" (March 13, 2024), TAB 181 BOD VOL 8.

dedicated to offering longitudinal family medicine, with a specific focus on improving access and fostering attachment. Physicians will be remunerated based on the hours they work, the services they deliver and their panel size, resulting in a multipronged remuneration structure.[336]

538. It's projected that family physicians working full-time to provide longitudinal family medicine will earn at least 20% more when compared to the previous models. Physicians under the LFM model will be paid a blended payment that is calculated based on hours worked, services delivered and panel size.

- Hours worked: $95.48 per hour (weekdays); $143.22 per hour (evenings/weekends)
- Services delivered: 30% of fee-for-service billings, with enhanced fee codes in place
- Panel size: $106.09 per patient[337]

539. In addition, there are numerous other initiatives to recognize the work and costs that physicians bear:

- Reduction of administrative burden: More than 45 initiatives have been identified, many completed, others underway, to reduce physician red tape by 400,000 hours per year, the equivalent of 1.2 million patient visits, by the end of 2024.[338]
- Overhead support: $20 per patient per year, up to 2,000 patients[339]
- Funding for Allied Health: $25 per visit done by Allied Health Care Provider up to $110,000 per year[340]
- Funding for invisible work: Including intake of new patients[341]
- CME funding: $2,000 per year[342]
- Locum funding: 30 days paid at $1,200 per day + $250 overhead[343]

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[336] Doctors Nova Scotia, *A New Path Forward Making the Longitudinal Family Medicine payment model work for you,* (March 2024), TAB 182 BOD VOL 8.
[337] Doctors Nova Scotia, "Longitudinal Family Medicine payment model," TAB 183 BOD VOL 8.
[338] Doctors Nova Scotia, "Reducing physician administrative burden," TAB 184 BOD VOL 8.
[339] Doctors Nova Scotia, "Overhead/attachment support (2023)," TAB 185 BOD VOL 8.
[340] Doctors Nova Scotia, "Funding for allied health-care," TAB 186 BOD VOL 8.
[341] Doctors Nova Scotia, "New fee codes for invisible unpaid work (2023)," TAB 187 BOD VOL 8.
[342] Doctors Nova Scotia, "Continuing Professional Development (CPD) stipends," TAB 188 BOD VOL 8.
[343] Government of Nova Scotia, "Locum Program Guidelines" (Effective July 24, 20223), TAB 189 BOD VOL 8; Doctors Nova Scotia, "Provincial locum program (2023)," TAB 190 BOD VOL 8.

- EMR Grants: $10,000 onboarding, $2,000 annual + utilization fund[344]
- Preceptor support: $5000 annual + $90/day + 5% billings[345]

d) Newfoundland and Labrador (Blended Capitation)

540. The Newfoundland and Labrador Medical Association ("NLMA") and provincial government reached an agreement on a new Blended Capitation payment model for family physicians. Blended Capitation is a voluntary, alternate payment model designed for independent community family practice. The model blends a capitation payment per each rostered patient with a partial fee-for-service payment for direct patient encounters. The new model supports comprehensive family medicine, improved access for patients, team-based care, and improved recruitment and retention of physicians who want to practice under this model.[346]

541. The new model represents a 21.8% increase in clinical compensation based on average family physician Medical Care Plan billing rates, on top of the 13.3% increases the prior year. Those who choose to enroll in the new payment model will also receive income guarantees to facilitate the transition.[347]

542. The blended capitation model payments feature:

- $180.97 per patient capitation
- 25% shadow billing
- Bonuses
- Admin funding

543. The key components of the model are:

A. 21.8% increase in clinical compensation for in-basket services, based on average family physician MCP billing rates

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[344] Doctors Nova Scotia, "Electronic Medical Records Grants," TAB 191 BOD 8.
[345] Doctors Nova Scotia, "Preceptor support," TAB 192 BOD VOL 8.
[346] Kris Luscombe, President, Newfoundland and Labrador Medical Association, "President's Letter; Blended Capitation Advisory Service," (April 14, 2023), TAB 193 BOD VOL 8.
[347] Newfoundland and Labrador Medical Association, "Blended capitation," TAB 194 BOD VOL 8.

B. One-time signing bonuses: a. $10,000 Start-Up Grant in recognition of start-up costs, such as renovations, technology, training, and legal services b. $11,250 Transition Grant upon acceptance into the Blended Capitation Model
C. Income to pay two-weeks of locum coverage
D. E. Annual bonuses for quality of care ($7,500) and volume of procedures ($2,500)
E. eDOCSNL EMR subscription costs paid by Government (plus a grant for those transitioning from a different EMR)
F. Two-year income guarantee while transitioning to new model, plus 10.9% premium in the first year
G. No negation (financial deduction) if a rostered patient receives care elsewhere
H. Revenue for practices who wish to hire/contract with nurse practitioners or registered nurses.[348]

e) Saskatchewan (TPM)

544. In the 2017-22 agreement, the Saskatchewan Medical Association and the Ministry agreed to form a joint Primary Care Compensation Working Group ("PCCWG") to make recommendations on future compensation models that better support community-based family physicians providing longitudinal care. The resulting recommendations were that, among other things, family physician compensation evolve toward blended capitation and family physician-led, team-based care. This is a long-term vision that will take years to advance. At the same time, the PCCWG clearly heard from physicians that there is urgency to support family physicians to continue to provide longitudinal family medicine in Saskatchewan.

545. As a result, in order to recognize and value the unique relationship between longitudinal FFS family physicians and their patients and the unpaid physician work resulting from this relationship, a new Transitional Payment Model ("TPM") was designed.[349]

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[348] Newfoundland and Labrador Medical Association, "Briefing on Blended Capitation," TAB 195 BOD VOL 8.
[349] Government of Saskatchewan, "Transitional Payment Model (TPM) Information," TAB 196 BOD VOL 8.

546. It's estimated that the TPM and agreement will result in a 43.4% increase to family medicine compensation.

547. A capitation payment of up to $144,000 per year in new funding will be provided to family physicians who enrol in the TPM. The formula has two parts: Unpaid Work and Patient Panel.

548. In addition to the panel payment numerous enhancements to family medicine have been announced:

- A new automatic 15% premium for rural/northern locations
- Innovation fund to enable team-based care: $10M annually
- Tracking codes for supervisory and multiple diagnostic codes
- Continuing Medical Education Funding: up to $3,500 per year
- Physician Retention Fund: up to $14,000 per year

f) Alberta

549. In partnership with the Alberta Medical Association ("AMA") and the Alberta government, Alberta is working towards a new payment model for family medicine. A separate memorandum of understanding has been struck to stabilize, transition and transform family medicine in Alberta.[350]

550. As an initial step, one-time funding has been provided to the AMA as part of a December 2023 commitment of $200 million over two years to stabilize primary health care. The AMA will distribute the funding to eligible family physicians and rural generalists.

551. Approximately 3,000 family doctors are eligible to receive transition funding of $24,000 to $40,000. The amount a family physician and rural generalist will receive depends on the number of patients they have.

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[350] Alberta Medical Association, "$100 million in stabilization family and rural generalist care," (December 21, 2023), TAB 197 BOD VOL 8.

552. The funding is a one-time payment aimed at helping family doctors and rural generalists until a new compensation model is in place. It will be used for administrative and equipment costs related to the number of patients they manage. Alberta Health sets out the conditions for payment and requires family physicians and rural generalists to sign a declaration in order to receive payment, in which they agree that this funding will be used to support panel management and practice improvement activities.

553. Family physicians will be allocated funding based on panel size. Family physicians and rural generalists with a minimum panel size of 500 will receive funding as follows:[351]

Location	Panel Size	Funding per Year
Urban	500 – 899	$4,000
Urban	900 – 1299	$8,000
Rural	500 – 1299	$8,000
Rural and Urban	1300+	$10,000

X. The OMA's Proposed Targeted Family Medicine Proposals

554. The OMA has developed a package of targeted proposals aimed at responding the crisis in family medicine in Ontario. For its part, the Ministry has proposed imposing further accountabilities and burdens on family physicians (when Ontario already has the most detailed accountability requirements and measures in the country). By contrast, the OMA's proposals focus on ensuring that family physician compensation is increased in order to attempt to address the crisis.

555. Unfortunately to this point in discussions and negotiations for the 2024-28 PSA, there has only been limited discussion between the parties about necessary improvements to family physician compensation. The OMA is hopeful that, as the mediation/arbitration process unfolds, the Ministry can be persuaded to recognize, as have other provincial governments, the need for improved compensation for family physicians.

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[351] Alberta Medical Association, "Panel Management Support Program," (April 5, 2024), TAB 198 BOD VOL 8; Government of Alberta, "Stabilizing Alberta's primary health care system," *supra,* TAB 142 BOD VOL 6.

556. The OMA's proposals are focused on addressing the various factors contributing to the current unquestionable crisis in family medicine including the need to employ financial incentives and compensation improvements to encourage both attachment and access, to respond to increasing patient complexity, and to lessen the overall workload burden on family physicians, and compensate where that cannot be done.[352]

557. However, one thing is clear: the need for enhanced compensation is urgent. While the specific allocation of targeted funding is not part of this initial arbitration, the OMA expects that once the amount of the Year 1 increase is determined by this arbitration, the Year 1 targeted funding will, in addition to other targeted measures outlined in this brief, include immediate targeted funding for family physicians, particularly given the extent and immediacy of the family medicine crisis.

558. Below, we identify and summarize some of the OMA's targeted proposals advanced and identified to date. At the same time, the OMA is open to other constructive and effective solutions to addressing the family medicine crisis, and reserves its right to advance different and additional proposals as this mediation/arbitration process unfolds.

a) Address the Unattached Patient Crisis with Unattached Patient Fee Codes

Proposal:

1. Create an incentive for new graduates/new to Province (New Grads) Patient Enrolment Model (PEM) physicians to enroll unattached patients. A New Graduate is a physician who has completed his/her family medicine post-graduate training and was licensed to practice within three (3) years of joining a PEM.

Payment for new graduates who enroll new patients would be:

[352] The proposals for compensation for administrative burden and medscheck/minor ailment workload, which apply, *inter alia*, to family physicians, are set out in Part H below

1. *$200.00 (for patients up to and including age 64 years)*

2. *$240.00 (for patients between ages 65 and 74 years inclusive)*

3. *$360.00 (for patients age 75 years and over)*

2. Create an incentive for existing PEM (not new grads) physicians to enroll unattached patients.

Payment for existing PEM physicians would be:

1. *$100.00 (for patients up to and including age 64 years)*

2. *$120.00 (for patients between ages 65 and 74 years inclusive)*

3. *$180.00 (for patients age 75 years and over)*

3. For those patients registered with Health Care Connect ('HCC') reinstitute the following Health Care Connect payments and Fee Codes:

- *Enhanced capitation payments of $500 for the first 12 months and 150% premium for Fee For Service (FHG, CCM) models for the first 12 months for patients deemed complex/vulnerable*

- *Q054 Mother Newborn New Patient Fee $350*

A one-time payment of $350.00 for physicians enrolling both an unattached mother and newborn within two weeks of giving birth or an unattached woman after 30 weeks of pregnancy.

- *Q055 Multiple/Newborn Fee $150*

In the case of multiple births, physicians may bill a Multiple Newborn Q055A fee code in addition to the Q054A Mother New Born New Patient

code for each additional newborn of an unattached mother and the claim will be $150.00 per newborn.

- *Q056 Health Care Connect (HCC) Upgrade Patient Status $850*

Where a physician accepts an HCC referred non-complex/vulnerable patient that the physician (in his/her clinical opinion) believes to be complex and/or vulnerable, the physician is eligible to bill the HCC Upgrade Patient Status Q056A fee code. When billing this code, physicians will receive a one-time payment of $850.00 in recognition of the Q053A one-time payment of $350.00 and the Complex FFS Premium ($500.00).

4. In addition to the new patient enrollment fee code, the OMA proposes to implement an 'on-boarding fee' of $40 to recognize the additional administrative time required to onboard and/or transfer patients. This on-boarding fee code will be available when the enrollment fee code Q200 (regular patient) or Q202 (LTC patient) is submitted by a physician.

559. As discussed earlier in the brief, Ontario is in the midst of an unattached patient crisis. A recent study conducted by INSPIRE-PHC shows there are 2.2 million Ontarians that do not have a family doctor, up from 1.8 million just three years earlier.[353] The OMA's proposals set out immediately above are intended to address this crisis by providing incentives to physicians to enroll these unattached and complex patients.

560. The OMA proposal creates enrolment payments for orphaned patients which would apply to all Patient Enrollment Models and incentivize increase access to care. It would be adjusted for social and medical complexity thereby compensating for the longer clinical time involved in the engaging and integrating new patients into the physicians' practices.

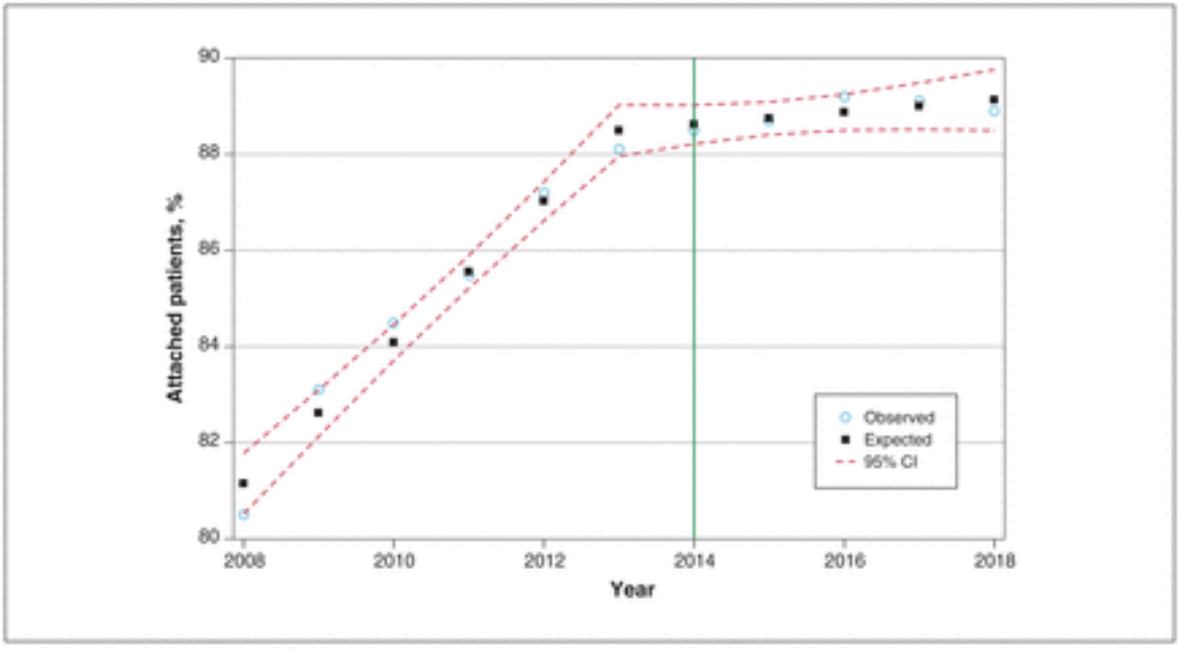
[353] OCFP, Background: INSPIRE-PHC Research Findings for Ontario, TAB 199 BOD VOL 8.

561. Ontario has used similar unattached patient incentives to address the orphaned patient issues with great success in the past.

562. In the early 2000s, when Ontario was facing a situation where there were nearly one million orphaned patients and more family physicians were leaving the province than entering, new family practice models were developed and implemented, and, over the decade (2000-2010), the OMA and the Ministry created and expanded numerous unattached patient codes, similar to those discussed above, which helped stabilize the orphaned patient crisis and encouraged physicians to formally enroll and attach patients.

563. As shown in a study by Bayoumi et al. 2023, in response to these incentives, attachment grew by 1.47% annually from 2008 until 2014 ($p < 0.0001$).[354] However, in 2014, the Ministry unilaterally eliminated the majority of the new unattached patient codes. This, combined with other MOH unilaterally imposed policies, dealt a significant blow to the progress made in attaching more Ontarians to a family physician. As confirmed by Bayoumi et al. and as reflected in the following chart, attachment was stagnant a thereafter (annual percent change of 0.13, $p = 0.16$):[355]

[354] Bayoumi I, Glazier RH, Jaakkimainen L, Premji K, Kiran T, Frymire E, Khan S, Green ME. "Trends in attachment to a primary care provider in Ontario, 2008-2018: an interrupted time-series analysis," CMAJ Open. 2023 Sep 5;11(5):E809-E819. doi: 10.9778/cmajo.20220167. PMID: 37669813; PMCID: PMC10482493, TAB 200 BOD VOL 8.
[355] *Ibid.*



564. According to Bayoumi et al., "[p]olicy changes between 2012 and 2015 to restrict access to alternate payment models may have negatively affected patient attachment, and trends may have differed for some groups."[356]

565. Other measures to address the earlier unattached patient crisis, implemented in 2004 and 2008, was an agreement to provide incentives to attach the most vulnerable patients, including new mothers and their newborns and medically complex patients. Health Care Connect ("HCC") was launched by the Ministry of Health to help Ontarians without a family health care provider find one. The program allows patients to call and register themselves on a provincial registry. A Care Connector then attempts to match them with a Physician in their community. At the time of sign-up, patients are asked a series of questions and deemed "complex" or not. Most critically, various incentives were created bilaterally to incentivize the attachment of HCC patients, including one specifically targeted to those patients waiting 3 months or longer.

[356] *Ibid.* at E810.

566. However, these Health Care Connect incentives were also unilaterally terminated by the MOH in 2014 and the family medicine crisis has grown since then with no targeted way to address it.

567. The OMA proposal above is intended to address the issues created at least since 2014 and, it is hoped, provide sufficient incentives to promote the attachment of patients—young, old, complex etc—to practices.

b) Increase the After-Hours Premium to 50%

Proposal:

The OMA proposes to increase the current after-hours premium fee from 30% to 50%. This will improve patient access to care during after-hours and be applicable to all Patient Enrollment Models. The increase will enable improved access to timely care for all enrolled patients and fairly compensate physicians for providing such care.

This change will apply to the following After-Hours fee codes and practice models:

- *Q012: FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA*
- *Q016: CCM*
- *Q017: HIV*
- *Q018: GP focus – COE1*

568. Encouraging family physicians to offer more after-hours care would provide improved access for attached patients.

569. Significant changes were made to the after-hours requirements for FHO physicians in the 2021 Physician Services Agreement. These changes increased the amount of coverage required by groups commensurate with their group size. Of course, additional

after hours coverage has also additional overhead costs such as staff-wages or hiring more staff.

570. The OMA proposal would provide additional incentives and compensation to allow and encourage family physicians to provide enhanced after-hours coverage.

c) Increase the Family Health Group premium to 20%

Proposal:

The OMA proposes to increase the current FHG premium to 20% to support the added work in maintaining continuity of care and ongoing going patient care coordination.

571. Currently the FHG Premium is 10% and applicable to the following fee codes:

A001, A002, A003, A007, A008, A888, A900, A902, C010, C882, G365, G538, G590, G840, G841, G842, G843, G844, G845, G846, G847, G848, K005, K013, K017, K022, K023, K030, K130, K131, K132 and K133.

572. The FHG premium has remained the same since its inception in 2004 whereas premiums applicable to other patient enrollment models such as the shadow billing and after-hours have both increased. There continue to be over 2,100 FHG physicians in Ontario managing the care of 2.7 mill patients. As outlined earlier in this brief, patient complexity and management of their longitudinal care has become more onerous over time. To reinforce support for and to incentivize longitudinal family practice by FHG physicians, this premium should be increased as proposed by the OMA.

d) Increase the Comprehensive Care Capitation ("CCC") Payment

Proposal:

The OMA proposes to create an enhanced Comprehensive Care Capitation ('CCC') from the current $2.86 per patient per month to $5.50 per patient per

month. The increase in the CCC fee will apply to all applicable models currently receiving this payment.

573. The Comprehensive Care Capitation fee is a key component of FHO and FHG and other PEM funding models that was critical to the stabilization of family medicine during the funding reform of the 2000s. It is an on-going monthly comprehensive care management fee to provide for the co-ordination and management of patients' overall care. This management fee is age/sex adjusted, recognizing that the management of the care of the elderly has become increasingly complex due to numerous diagnostic tests and procedures required from family physicians acting in the care coordinator role.

574. This fee is directly tied to the enrollment of a patient to a Family Physician and is not part of episodic – or walk-in – practice style. It is only available to those physicians and patients who have formally established a longitudinal relationship initiated by the signing of the Enrollment and Consent form.

575. Increasing this fee will further incentivize family physicians to maintain and increase patient attachment, and provide physicians with improved financial support in all areas of providing longitudinal comprehensive family medicine care, including recognizing the range of uncompensated work performed by family physicians as described elsewhere in this brief.

e) Eliminate Negation and Reinvest the Maximum Special Payments

Proposal:

The OMA proposes to eliminate negation for all models, and reinvest the money into the capitation base rate and/or shadow billing increases, or such other initiatives as the parties may agree

576. Under the FHO model, there is a financial holdback of approximately 20% (the Maximum Special Payment or MSP) from the base capitation payments for "in basket" services provided to capitated patients. Where patients receive in-basket services from

family physicians outside of the FHO group, the MSP is reduced by the full value of the service provided, commonly referred to as negation. This negation does not apply in certain circumstances, for example, where the services are provided by designated family medicine focus practice physicians. Groups receive a payment from this holdback if their patients' outside use is less than the MSP. However, if the outside use is greater than the MSP, no payment is made to the group.

577. A 2019 study by Glazier et. al. examined the access bonus, and recognized that while it was designed to be a bonus to incentivize primary care access and to minimize family physician visits outside of capitation practices, there was "a lack of alignment between these payments and their intended purpose."[357]

578. Furthermore, as long ago as 2012, a jointly established OMA–MOHLTC Access Working group concluded that geography, providers' experience with the patient enrolment models, and patient choice and convenience play the most important role in explaining variations in outside use across groups.

579. Geography plays a significant role in the amount of negation.[358] Physician groups with lower RIO scores in urban areas receive, on average, a smaller access bonus than groups with higher RIO scores (in 'rural' and 'isolated' areas). This result is also undoubtedly also influenced by patient behaviour, convenience and choice. Individuals who work in an urban area may well live in a rural area or in a different urban area and access their health care where it is convenient, notwithstanding their enrolment in and commitment to their main family physician. In urban areas, the availability of walk-in clinics undoubtedly induces patients to go "next door" to the clinic or use the rapidly expanding and insured "mobile services" rather than their FHO physician.

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[357] Richard H. Glazier, Michael E. Green et. Al, "Do Incentive Payments Reward The Wrong Providers? A Study Of Primary Care Reform In Ontario, Canada," Health Affairs 38, NO. 4 (2019): 624–632 doi: 10.1377/hlthaff.2018.05272, TAB 201 BOD VOL 8.

[358] Shaikh S., Weir S., Alam N., Matthew S., Sibley L., and Kantarevic J. *Primary Care Use with Outside Providers: Multilevel Analysis of Family Health Organizations in Ontario, Canada*. 2024. Submitted to BMC Health Services Research, TAB 202 BOD VOL 8.

580. As the C.D. Howe institute concluded several years ago, “visits outside of one’s family doctor are largely due to patient choice based on convenience of care.” It further finds that “a number of factors can cause Ontarians enrolled in capitation plans to access outside providers, such as preference to receive care on weekends or non-work hours, at a location near home or work.”[359]

581. Negation is a significant source of frustration to Ontario FHO physicians. Even when physician offices are open and available, negation occurs due to geography, patient choice, and other factors – all of which are generally beyond the ability of the physician to control notwithstanding their best efforts to do so.

582. In addition, negation occurs in other circumstances that are unfair to the physician who has enrolled the patient. For example, if a patient presents to the emergency department with a laceration of 10 cm requiring sutures, the family physician would be negated if the attending emergency doctor is also a family physician. Similarly, if a patient goes to the emergency with acute crushing chest pain and receives an ECG as a part of their emergency care, both the technical and professional components of the ECG will cause negation to the family physician. This occurs because these codes are part of the FHO basket, but the FHO contract does not differentiate between service locations and as such continues to cause negation when in no way the responsibility of the FHO Physician.

583. It is increasingly common for patients to require more than one family physician to effectively manage their growing family medicine needs. This is due to various factors such as increasing complexity of medical conditions and the need for specialized expertise, as well as the reality of patients seeking care across variable geographies (e.g. different work location than residence, schooling, vacation/cottaging). Patients with multiple chronic illnesses or complex health care requirements also undoubtedly benefit from collaborative care involving multiple physicians who can bring complementary skills

[359]Åke Blomqvist, Boris Kralj and Jasmin Kantarevic, “Accountability and Access to Medical Care: Lessons from the Use of Capitation Payments in Ontario.” CD Howe Institute Essential Policy Intelligence E-Brief (November 19, 2013), TAB 203 BOD VOL 8.

to the table. This collaborative approach allows for a more comprehensive and tailored approach to health care, ensuring that patients receive the right care at the right time.

584. Furthermore, the Ontario government is building a connected health care system - with Ontario Health Teams - centered around patients, families and caregivers. These changes will strengthen local services, making it easier for patients to navigate the system and transition between providers. With Ontario Health Teams, health care providers work as one coordinated team – no matter where they provide care. The current construct of the Access Bonus and associated outside use can be seen as impeding these efforts to regionalize and coordinate care.

585. Separate and apart from these concerns, negation also unnecessarily adds to the growing administrative burden of managing a longitudinal family medicine practice. More significantly, eliminating negation from the FHO compensation arrangements has been consistently and overwhelmingly identified by FHO physicians as a critical change which would encourage both recruitment and retention of family physicians.

586. Notably, at the same time as other provinces are injecting significant additional funding support for family medicine, none are implementing any form of negation or penalty.

f) Modernizing the Managed Entry Co-Location Guidelines and Limits

Proposal:

The OMA proposes to modify the co-location guidelines that were established as part of the 2021 Physician Services Agreement as follows:

- *If all physicians in a group cannot be in the same location, there should be no fewer than 2 (as opposed to the current 3) physicians in each location.*
- *Close proximity to be defined as the FHO locations being within a 10km radius (as opposed to the current 5 km) of one another, where there is a RIO score of 0.*

- *In areas with a RIO score of 1 or more, applications from groups will be permitted where they cannot locate within 30 km (as opposed the current 5 km) due to infrastructure limitations or any other relevant factors, having regard to the primary health care needs of the community.*

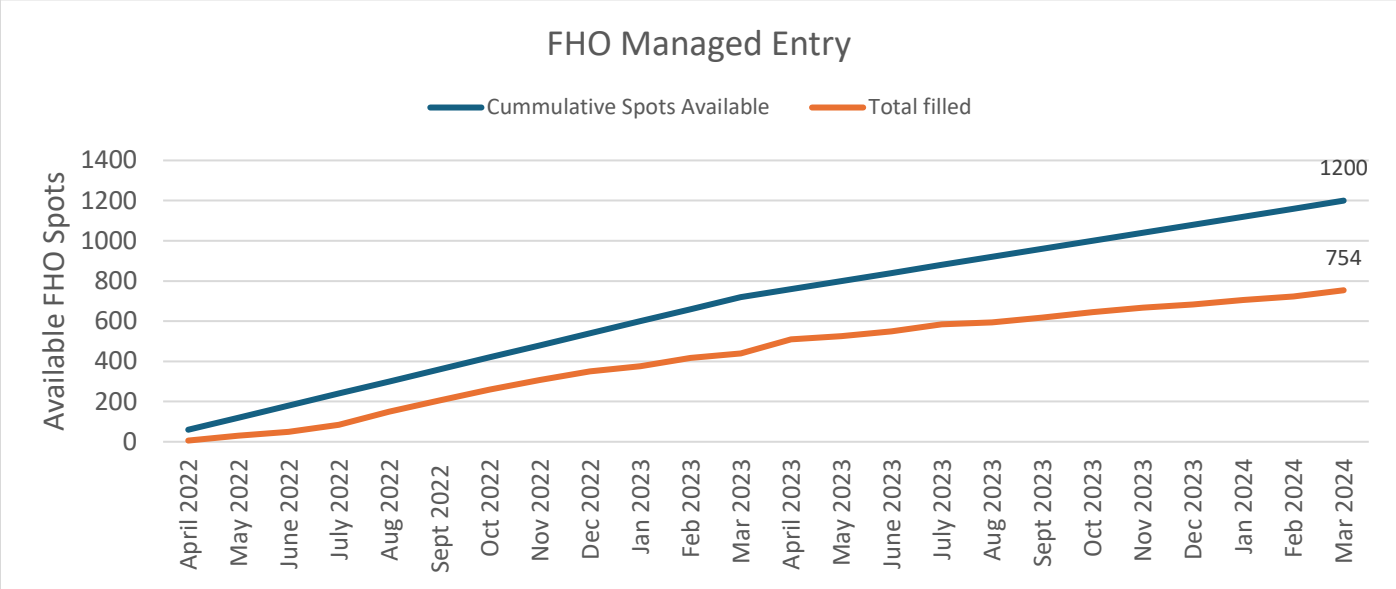
Furthermore, the OMA proposes to lift the managed entry restrictions on expanding FHOs by 40 physicians per month established in the 2021-24 PSA.

587. The Co-Location guidelines set out under the 2021 PSA have created barriers for physicians to join FHO team-based care. The OMA proposes to liberalize these guidelines, in the manner set out above, with a view to promoting access to this model.

588. The current co-location guidelines put added pressure and restrictions on family physicians wishing to join a FHO. While they are only “guidelines”, the ministry has treated them as strict requirements and has demonstrated a significant lack of flexibility in this area.

589. Managed entry limits on the number of physicians that could join a FHO every month were imposed by the Ministry as part of its unilateral actions a decade ago, and at a time when we were not experiencing a family medicine crisis. Lifting both the co-location and managed entry restrictions would induce more doctors to enter into the FHO model and attach more patients**.**

590. In fact, as set out in the chart below, less than 65% of available FHO spots created under the 2021-24 PSA have been filled, at least in part due to the inflexibility of the ministry application of the current “guidelines”. Eliminating this barrier would aid in increasing access to comprehensive family medicine.



g) Community Health Centre – Alignment and Expansion

Proposal: Expansion and Alignment of CHCs

1. *Expansion of CHC FTEs*

The OMA proposes the expansion of CHCs of an additional 100 FTE.

2. *Eliminate the payment grid of CHC physicians*

The OMA proposes to align all CHC physicians to the upper range of their salary grid. To ensure fairness, equity and transparency, all CHC physicians should be paid at the same level.

591. An expansion of CHCs would directly meet the needs of vulnerable, complex and marginalized patients, and alleviate pressures elsewhere in the system.

592. Furthermore, improving compensation for CHC physicians would recognize the work they are providing and support both recruitment and retention.

h) Location of Service within the FHO/FHN

Proposal

The OMA proposes that core services provided to rostered patients with a hospital number (4 digit Master Number) or a Service Location Indicator are considered out of basket and paid full fee for service.

593. FHO Physicians working in rural and remote communities tend to be comprehensive rural generalists providing all the care needed in the community. These FHO physicians staff the hospital, emergency department, perform deliveries, and any other medical services required of them.

594. Currently the FHO/FHN contract does not separately recognize or identify core services provided by FHO/FHN physicians in non-office settings. This significantly impacts rural communities where the primary care group is also providing all the medical care necessary.

595. Due to these expectations and the fact the funding model does not differentiate the types of work, this has become a significant barrier to recruitment, retention and even temporary locum relief, for these communities.

i) Integration of Walk-In Clinics with Primary Care

Proposal

The OMA proposes the creation of two fee codes (Qxx1, Qxx2) for the transmission (Qxx1 - $7.50) and the review (Qxx2 - $15) of a summary of a visit to a walk-in clinic. To be eligible for the code, there must be a digital transmission of the summary (with minimum information that will be relayed to the family doctor-TBD). These fee codes will be out-of-basket.

596. As part of the 2021 Physician Services Agreement the parties agreed they would work together to develop a framework that will enable and ultimately require walk-in clinics

to communicate back to the patient's primary physician with respect to the reason for the visit, as well as the diagnosis and treatment, if any. This applies to both in-person and virtual services.

597. To help facilitate and recognize the burden associated with the communication between walk-in clinics and the patient's physician the OMA proposes the creation of codes to allow for better data collection and understanding of walk-in services being provided in Ontario, i.e., the Ministry may be able to identify which doctors/clinics are providing walk-in care.

598. As well, these new fee codes will allow for enhanced integration, better patient care via continuity of information, reduction duplication of services, and recognition of the additional burden and strain on physicians' time.

j) Quality Improvement

Proposal:

The OMA proposes a payment of a QI stipend of $5,000 per physician in PEM models, including FHO and FHG, up to a maximum of $100,000 per group. The QI funds will be utilized in accordance with the group's governance arrangements and only for the purposes of achieving the goals of the QIP and/or building physician skills and knowledge to support quality improvement.

To further support improvement, the Ministry will provide incentive funding to FHO physicians to effectively use the EMR to implement the annual QIP and other improvement efforts. The proposed funding amount is $400 monthly per FHO physician, which is equal to standard EMR licensing/maintenance fees in the province.

599. Annually, Health Quality Ontario ("HQO") creates a Quality Improvement Plan ("QIP") cycle. This year's QIP program requirements align with system priorities to support quality care in Ontario as follows:[360]

1. Access and flow
2. Equity
3. Experience
4. Safety

600. In order to support QIP initiatives, the OMA proposes that the the PSA provide for necessary funding support to encourage wider adoption of quality improvement initiatives.

k) Bilateral Rural and Northern Physician Group Agreement ("RNPGA") Working Group

Proposal:

The parties agree to set aside a targeted $15M and to strike a bilateral RNPGA working group to address shortcomings and repair in the RNPGA contract such as:

- *Reductions stemming from the complement review*
- *Locum days during vacancies*
- *Vacancy funding continuance*
- *Overhead funding for type 2*
- *Definitions of Type 1 and Type 2 communities*
- *ED funding for communities with 24/7 emergency departments*
- *And other challenges faced by these communities.*

601. The Rural and Northern Physician Group Agreement ("RNPGA"), is a specific funding model for 38 of the most remote communities in Ontario. The RNPGA was

[360] Memo from Dr. David Kaplan, Vice President, Quality, Clinical Institutes and Quality Programs, Ontario Health, to CEOs, executive directors, and quality improvement leads in hospitals, long-term care homes, and interprofessional primary care organizations, dated November 22, 2023, RE: Launch of the 2024/25 Quality Improvement Plan program cycle, TAB 204 BOD VOL 8.

introduced in 1996 to improve support, increase the financial feasibility of working in the north, in part by encouraging the creation of formal physician groups. Each group is funded by the Ministry of Health ("MOH") for a specific number of physicians (complement) using a blended funding model to provide core health care services, including hospital and emergency services in those communities having hospitals, for the population in the group's catchment area.

602. As part of the 2021-24 PSA the parties agreed to establish a time-limited bilateral working group to create a methodology and implement an RNPGA complement review for all RNPGA communities. Numerous challenges arose from this review that the Complement Review Committee were not able to address. There was insufficient funding assigned to appropriately fund RNPGA at their higher agreed to complements. For example, larger groups did not receive additional Emergency Department funding, even though the original funding formula adjusted ED funding by complement size.

603. Furthermore, for groups that receive overhead funding, if their new complement exceeded 2 MDs there was no additional overhead allocation for the additional increases in FTE complement. This lack of overhead funding results in recruitment challenges for these groups.

l) Indigenous Health and Populations

The parties are currently participating and engaging with indigenous groups and other key stakeholders (to this point, in Kenora and Sioux Lookout) on issues impacting Indigenous Health and populations, and requiring additional compensation for family physicians to improve recruitment and retention.

D. EMERGENCY MEDICINE

604. Emergency medicine ("EM") in Ontario is facing unprecedent challenges as Ontario's emergency safety net collapses. This crisis is reflected in the over 200 temporary emergency department ("ED") closures in 2023, the permanent reduction in services at several ED across the province, longer wait times for patients who present at emergency rooms, and growing recruitment and retention issues for emergency physicians. As well, an increasing number of hospitals are dependent on locum support while, at the same time, the locum pool cannot meet this increasing demand.[361]

605. Compounding these problems, ED services have become the default care provider for a health care system under strain for the millions of patients who do not have family physicians. After hours, the ED is, more and more frequently, the only available resource for patients seeking care for all health care needs, including acute injury, acute mental health crises, addictions, shelter and even food insecurity. When hospital inpatient and surgical units are full, the ED doubles as inpatient and surgical units while managing the influx of new patients.

606. With a growing and aging population needing more complex care and the need to provide frontline care for vulnerable communities, the challenges facing EM only continue to grow and the situation has become unsustainable for emergency physicians whose practice, even under the best circumstances, is stressful, intense and high pressure.

607. The OMA's targeted proposals regarding EM are designed to address these challenges and are aimed at rebuilding the EM community of practice. They are:

- Increase base payment to Emergency Department Alternate Funding Agreements ("EDAFAs") and apply equivalent flow through to non-EDAFA groups
- Adjust Hours of Coverage under EDAFA agreements
- Provide funding for emergency care to uninsured patients who are OHIP eligible

[361] Office of the Auditor General of Ontario, "Value for Money Audit: Emergency Departments" (December 2023) at pp 1-4, ("OAG ED Report") TAB 205 BOD VOL 8.

- Establish an Emergency Department Task Force

I. Background to Funding Models

608. In order to appreciate the OMA's proposals, it is necessary to understand the payment models in place for emergency physicians. The majority of emergency department physicians in Ontario are compensated through an EDAFA whereby all emergency department physicians working at a particular ED are part of the same alternate funding agreement ("AFA"). While most physicians are funded through an EDAFA model, physicians practicing at some departments are funded on a fee-for-service basis or through site specific comprehensive alternative funding plans.

609. Pursuant to an AFA, emergency physician groups contract with the Ministry to provide 24/7 physician ED coverage in return for a negotiated lump sum. There are two models of funding used to determine the amount paid: a 24-hour model used for smaller EDs and a workload model for larger EDs. The lump sum is determined by the volume of visits (24-hour model) and/ or volume and acuity of patients (workload model) to the ED in question. EDAFA physicians also record service encounters (shadow bill) they provide.[362]

610. EDAFAs were initially negotiated in the late 1990s to help stabilize emergency services. Although initially successful, the funding levels have not been sufficient to ensure an adequate supply of ED physicians and have not kept pace with changes in how EM is practiced. Once again, an influx of funding is needed to stabilize emergencies services.

611. In 2005, the OMA and the ministry commissioned a Predictors of Workload in the Emergency Room ("POWER") Study. The purpose of the study was to better estimate the amount of time required by emergency physicians to assess and treat patients in each

[362] An overview of the EDAFA models can be found in the OMA Powerpoint presentation *EDAFA Overview, 2024,* TAB 206 BOD VOL 8.

triage level and apply those results to the AFA workload model used to fund hours of coverage in larger EDs.

612. Since the POWER study was completed, significant changes have taken place in Ontario EDs including:

- An aging population, resulting in more complex patients, often with multiple medical comorbidities;
- The introduction of computer Physician Order Entry, and electronic medical records;
- Increasing overall patient volumes with frequent overcrowding and the need to care for patients in non-traditional spaces;
- Increasing numbers of patients with mental health and addiction challenges;
- Pressures to discharge sicker patients directly from the ED and to manage them as outpatients;
- Increasing delays in moving admitted patients out of the ED leading to further overcrowding and care in non-traditional spaces;
- Increasing delays for EMS in off-loading ambulance patients; and
- The introduction of electronic triage (eCTAS).

613. All of these changes have affected the time required to care for patients in the ED and the estimates of the original POWER study were recognized universally as requiring updating.

614. Through the 2021 PSA, the OMA and the ministry agreed to establish a working group to review and recommend amendments to the EDAFAs. This included an

agreement to conduct another POWER study, which has been delayed in part due to the pandemic and is unlikely to be completed prior to summer of 2025.

615. Although the results of POWER study do not apply to the current funding formula for smaller EDs, in the OMA's view, adjustments to these smaller sites must be made in parallel with any adjustments made to hours of coverage at larger EDAFAs.

616. Moreover, in recognition of the additional time needed to care for COVID probable patients during the pandemic, the OMA and the ministry agreed to increase hours of coverage at EDAFA by up to 20%. Many EDs continue to use these additional physician hours to reduce backlog and wait times in EDs. Nonetheless, the Ministry has now reduced the additional hours of coverage from 20% to the current 5%, placing additional strain on scarce ED resources. Without the return to full "surge funding" and the implementation of the POWER study results, many EDs across the province continue to woefully underfunded for the number of shifts needed. Chronic understaffing will lead to further physician burnout and likely closures.

II. Challenges Facing Emergency Medicine

617. The challenges facing EM currently are being felt every day throughout the province. Nowhere are these challenges more evident than in the temporary closures of EDs and growing ED wait times.

618. Although very rare before 2019-20, in the past few years, Ontario has seen an increasing number of ED closures and partial closures. Between July 1, 2022 and August 31, 2023, Ontario's EDs experienced more than 230 shift closures.[363] This figure does not include permanent reductions in services at some EDs across the system. Although some of these closures are due to shortages of nursing staff, closures due to physician shortages are also occurring more frequently, even with the existence of multiple locum

[363] OAG ED Report, *supra* at p. 1.

programs to serve as a stop gap measure. These closures due to ED physician shortages have been widely reported in the media and occur throughout the province.[364]

619. Along with closures, wait times in EDs are increasing. As reported by the Auditor General of Ontario, patients have to "wait on average two hours just to be assessed by a physician" and some "patients who require an inpatient bed have had to wait more than 24 hours, and many continue to be treated in emergency department hallways when space is not available." These wait times have increased significantly recently. For example, "[p]atients in the 90th percentile (the longest wait time after the top 10% of wait times are removed) waited up to 257 minutes (or more than four hours) in 2022/23, up from 183 minutes in 2013/14. As well, in "2022/23, patients waited an average of 13 hours for an inpatient bed, a significant increase from the approximately eight hours they had to wait 10 years earlier. Patients in the 90th percentile waited as many as 35 hours for an inpatient bed, up from about 21 hours in 2013/14.[365]

620. In addition to closures and increasing wait times, hospitals have become more and more dependent upon locum programs to keep their EDs open. The Emergency Department Locum Program ("EDLP") is a permanent locum support program offered through Ontario Health. This program was initially negotiated as part of the 2006 Emergency Department Coverage Incentive Program negotiated between the OMA and the ministry.

621. While initially designed as an interim measure of last resort for designated hospitals facing significant challenges covering ED shifts, it has increasingly become the main resource for staffing some EDs.

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[364] See for example Queens Journal: Something has to change in Ontario health care (Sep 1, 2023), TAB 207 BOD VOL 8; CTV: Critical shortage of ER doctors in North Bay (Sep 30, 2023), TAB 208 BOD VOL 8; Inside the Village: The doctor is out: Why one small town was forced to shut down its emergency room (May 25, 2023), TAB 209 BOD VOL 8; Bay Today: Doctor shortage: Now the emergency ward in Blind River is closing (May 31, 2023) TAB 210 BOD VOL 8; Belleville Intelligencer: Expect ER delays due to doctor shortage: Quinte Health (June 29, 2023) TAB 211 BOD VOL 8.

[365] OAG ED Report, *supra* at pp. 1,4.

622. As noted in the 2023 Auditor General of Ontario report, the number of hours covered by Ontario Health's EDLP grew by 40% in the summer of 2023 compared to the previous year, with EDLP covering nearly 20,000 hours last summer. At the same time, the locum pool is becoming less able to meet these increasing demands. As found by the Auditor General, "while hospitals requested over 96,000 hours of support from the Locum Program in 2022/23, the program was only able to cover approximately 60,000 hours...due to an overall shortage of emergency department physicians."[366]

623. In addition to the EDLP, there is also the Temporary Locum Program ("TLP"). Originally started during COVID as an emergency measure to keep EDs open during the pandemic, it has been repeatedly extended (most recently until September 30, 2024). The program allows eligible hospitals to "provide eligible ED physicians access to premiums in the highest-need rural and northern hospitals to maintain 24/7 ED services and to facilitate the safe operation of EDs."[367]

624. Although the rates/funding parameters paid under the TLP match those offered through the EDLP, the program is offered to a much larger group of hospitals including all Rural and Northern Physician Group sites, all 24hr model EDAFAs, and some Workload Model EDAFAs. Additionally, physicians on TLP are subject to fewer of the eligibility criteria/requirements in place for the EDLP program. For example, EDLP does not allow physician to participate in locum coverage if he/she worked in an EDLP site in the previous 6 months. Similarly, EDLP does not allow physicians to provide locum coverage (at EDLP rates) at the physician's home hospital. This is not a restriction of the TLP program.

625. These TLP premium rates are also significant. For Tier 2 EDs (those with 9,000+ annual visits), the additional premium is $72.66 an hour. The uptake under the TLP

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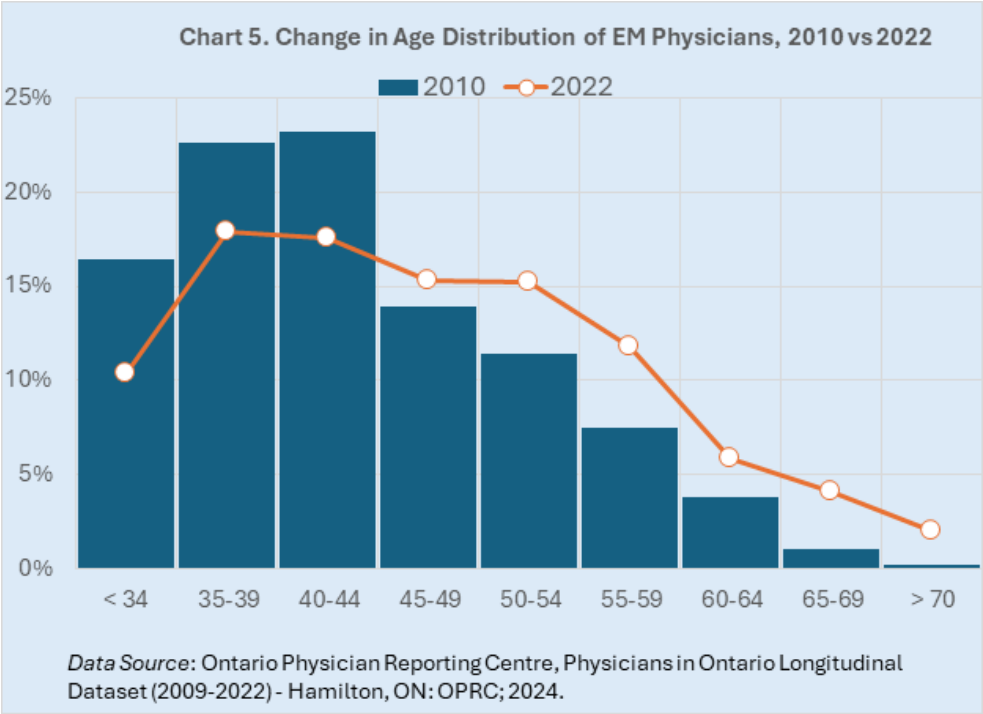
[366] *Ibid.*

[367] Ministry of Health, Temporary Locum Program (TLP), Frequently Asked Questions, Spring 2024, TAB 212 BOD VOL 8; see also Ministry of Health, Temporary Locum Program (TLP) Program Guide, Spring 2024, TAB 213 BOD VOL 8.

program is itself evidence of the fact that increasing compensation is a key part of addressing the physician shortages facing EDs.

626. Without additional increases to funding and compensation, the challenges facing EM will only worsen, particularly as recruitment and retention issues increase. For example, as noted at paragraph 286 above, between 2009-10 and 2018-19, the supply of EM physicians grew on average by 5.1% per year, but has declined in the pandemic and post-pandemic period to about 1.4% per year. Moreover, as noted in paragraph 288 above, the attrition of EM physicians is also higher by about 1 percentage point (or by 46%, from 2.3% in the pre-pandemic period to about 3.3% in the post-pandemic period).

627. In addition to the increase in physician vacancies discussed in paragraph 289 above, there is also proportionately more EM physicians in the later career stage in the post-pandemic era, increasing the possibility for earlier retirement and its impact on access compared to the pre-pandemic era.



628. At the same time as recruitment and retention issues intensify, patients presenting at EDs have increasingly complex health issues. As set out in paragraph 43 above, this increasing complexity is documented in the increased proportion of high-acuity ED visits over time, from about 64% for CTAS Levels I-III in 2013-14 to about 75% in 2022-23, an increase of about 17%.

629. Stated alternatively, due to higher complexity of ED visits, it is estimated that each ED visit today takes about 4 minutes longer on average than it did in 2009-10, an increase of about 17% (from about 23 minutes per visit in 2009-10 to about 27 minutes per visit in 2022-23), equivalent to about 3 patient visits per 8-hour shift. The estimated time is based on the POWER study conducted almost two decades ago and is, almost certainly, a significant underestimate. As per the 2021 PSA, the Parties have agreed to conduct an updated POWER study. As the average complexity of an emergency physician's shift has increased, so top has stress and burnout.

630. At present, emergency physicians face incredible challenges. They must be capable of and ready to provide care to patients with acuity-levels as high as in the ICU and as complex as internal medicine patients, as virtually all patients admitted to these services are first diagnosed and treated/stabilized by the ED physician, for less money than their ICU and internal medicine colleagues. As well, the ED also continues to experience rates of violence at least comparable to those facing policing or correctional officers,[368] which only adds to the stress and challenge of being an ED physician. As has been recognized in the literature, "[f]or physicians and nurses working in emergency departments in Canada, no end is in sight for growing patient volumes and crowding, and the demand for emergency care exceeds the capacity of emergency medicine health human resources in all regions of Canada now and for the foreseeable future."[369]

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[368] See for example, Drummond A, Chochinov A, Johnson K, Kapur A, Lim R, Ovens H. CAEP position statement on violence in the emergency department. CJEM. 2021 Nov;23(6):758-761. doi: 10.1007/s43678-021-00182-z. Epub 2021 Aug 5. PMID: 34351599, TAB 214 BOD VOL 8; Canadian Federation of Nurses Unions (CFNU) "Enough is Enough: Putting a Stop to Violence in the Health Care Sector", 2017, TAB 215 BOD VOL 8.

[369] Catherine Varner, "Emergency departments are in crisis now and for the foreseeable future," CMAJ June 19, 2023 195 (24) E851-E852; DOI: https://doi.org/10.1503/cmaj.230719, TAB 216 BOD VOL 8.

631. The OMA submits that long-term funding stability and compensation increases are critical to addressing physician recruitment and retention crises in EM. This must include enhancements to base rates paid to emergency physicians to help retain existing physicians and recruit new ones. Additionally, funding to expand capacity is required to account for increasing volumes and the complexity of patients presenting at EDs. The parties must also undertake a review of the locum programs with the aim of stabilizing and expanding local physician staffing and thereby reducing reliance on the EDLP and the TLP to maintain ongoing coverage. As well, OMA and the ministry must implement incentives to allow for recruiting physician extenders in the EDs (dealt with elsewhere in these submissions under the topic of Physician Extenders).

632. The OMA's targeted proposals for EM are aimed at addressing the need to increase compensation needed to recruit and retain ED physicians in order to keep emergency rooms open, and to provide additional hours of coverage under EDAFAs, along with creating a forum for ongoing discussions to continue to address the challenges facing EM.

III. OMA ED PROPOSALS

a) Increase base payment to EDAFAs and apply equivalent flow through to non-EDAFA groups

633. Since the EDAFA was introduced in late 1990s, the hourly rates under these agreements have seen only a very modest increase. For example, the hourly rate for the first 24 hours of coverage at higher volume hospitals has gone up from $150/hour in 2000 to $169.90/hour in 2024. This represents only a 13.2% increase over the course of 24 years.

634. In the absence of a significant correction, lower risk, daytime, higher paying work will continue to attract physicians away from EM resulting in more ED closures and staffing issues, which, in turn, will result in negative outcomes for patients and more negative reputational damage to the health care system as a whole.

635. Other Canadian jurisdictions have already recognized the importance of ensuring appropriate remuneration for emergency physicians. For example, the Nova Scotia government has recently agreed to new hourly rates of between $250-$260 per hour for comparable larger volume hospitals. Similar hourly rates are in place at larger EDs in Newfoundland and New Brunswick.

636. In Ontario, physicians also report some hospitals supplementing the extra hourly rate provided by the Locum Programs, discussed above. Some of these anonymized examples of bonuses and “top ups” being offered for ED coverage, above and beyond FFS or shadow billing income, include a medium volume ED in the southwest that serves as a regional hub posting shifts offering $345 to $400/hour (so that when EDLP bonuses are factored in the total pay rate is $556/hour plus travel support). Smaller volume EDs in the same region offer $225 to $265/hour with EDLP on top that equating to $400/hour plus travel. An urban, academic hospital that has staffing challenges is receiving $100,000/month to be used as a bonus for the existing group members who pick up open shifts, which would equate to thousands of dollar each shift. An important northern, medium volume, regional hub hospital pays an additional $125/hour for all shifts in addition to existing AFA/EDLP rates; a southeastern multi-site corporation spent $200,000 in 3 months over the summer (mid-June to mid-Sept) to bonus shifts at 1-2 of their sites who were struggling to provide coverage in addition to the EDLP or TSLEP funds. Another Southeast corporation struggling with coverage following some local re-organization is offering $110/hour over base rates, with other arrangements where staff from the providing hospital receive $300/hour in addition to shadow billing for covering daytime shifts ($400/hour for weekends/evenings and $500/hour for overnight). As well, some RNPGA sites are doubling their base rate to secure weekend coverage.

637. Obviously, it has been difficult for the OMA to obtain this information, as the hospitals and physicians are reluctant to document this information as the payments may violate existing agreements. Nonetheless, the above examples clearly demonstrate the efforts that sites are undertaking to meet their ED demands and that increased compensation can be an effective incentive.

638. In order to address the need for increased compensation for ED physicians, the OMA is proposing the following changes to the workload hourly rates:

Southern Ontario	2021 PSA (2.0524%) April 1, 2023	Proposed Rates
First 24hrs	$ 169.90	$ 275.00
40% over 24hrs	$ 169.90	$ 275.00
40%-55% over 24hrs	$ 186.75	$ 302.28
55%-75% over 24hrs	$ 192.28	$ 311.22
75%-90% over 24hrs	$ 197.80	$ 320.16
90%-100% over 24hrs	$ 203.88	$ 330.00

Northern Ontario	2021 PSA (2.0524%) April 1, 2023	Proposed Rates
First 24hrs	$ 169.90	$ 275.00
40% over 24hrs	$ 169.90	$ 275.00
40%-55% over 24hrs	$ 192.28	$ 311.22
55%-75% over 24hrs	$ 197.80	$ 320.16
75%-90% over 24hrs	$ 203.88	$ 330.00
90%-100% over 24hrs	$ 209.41	$ 338.94

639. In line with the above increases for the larger EDs, the OMA is requesting equivalent adjustments to funding levels for smaller EDs covered by a 24-hr EDAFA model.

		Existing April 1, 2023 Rates			New Rates		
Hospital Volume	Hospital Volume Level	Option 1 Base Funding	Option 2 Base Funding	Second On-Call Physicians'	Option 1 Base Funding	Option 2 Base Funding	Second On-Call Physicians'

				Billing Limit			Billing Limit
Less than 3,500 Visits	A	719,092	829,459	6,080	1,163,922	1,342,562	9,842
3,501 - 5,000 Visits	B	821,895	951,854	9,121	1,330,319	1,540,670	14,763
5,001 - 7,500 Visits	1	1,026,780	1,185,987	12,161	1,661,945	1,919,637	19,684
7,501 - 12,500 Visits	2	1,129,282	1,309,620	18,241	1,827,855	2,119,749	29,525
12,501 - 17,500 Visits	3	1,232,085	1,430,983	24,322	1,994,251	2,316,187	39,367
12,501 - 17,500 Visits	3A	1,355,704	1,563,086	31,724	2,194,341	2,530,010	51,348
17,501 - 20,000 Visits	4A	1,389,103	1,619,721	31,724	2,248,401	2,621,678	51,348
20,001 - 22,500 Visits	4B	1,438,714	1,680,127	47,586	2,328,701	2,719,452	77,023
22,501 - 25,000 Visits	5A	1,488,325	1,734,426	63,448	2,409,001	2,807,341	102,697
25,001 - 30,000 Visits	5B	1,513,130	1,770,644	84,597	2,449,151	2,865,963	136,929

Note: Above proposed rates to be adjusted by increases to emergency medicine resulting from year 3 of the 2021-24 PSA

640. In the OMA's view, these targeted increased rates are necessary to support recruitment and retention of physicians across different EDs.

641. The new hourly rate will also provide for sufficient funding so that each emergency group can make premiums available to incentivize after hour work. As it stands now, there

is insufficient funding provided to permit a reasonable daytime hourly rate, while also providing for premium payments for after-hours and weekend work.

642. To prevent destabilization of emergency services it is also critical to ensure that physicians practicing at departments which are funded through FFS or other AFP arrangements receive equivalent adjustments.

b) Adjustment to Hours of Coverage under EDAFA agreements

643. Given the delays with the conclusion and implementation of the POWER study, it is imperative that sufficient hours of coverage are made available to EDs to care for higher volumes and the increased acuity of patients presenting at Ontario's EDs. For this reason, the OMA proposes immediate reinstatement of the EDAFA surge funding to its original levels until the POWER study is complete. Further, the OMA proposes that the parties also commit to implementing the results of the POWER study through necessary increases to funding and to applying equivalent Hours of Coverage adjustments to 24-HR models.

644. In sum, OMA proposes that, until results of the POWER study are known and implemented, EDs must be allowed to increase hours of coverage to address ED wait times, as follows:

- Interim funding to allow EDs to increase physician coverage by up to 20%, reducing ED wait times and physician burnout
- This interim funding to be converted into new hours of coverage as determined through the POWER study

c) Provide funding for emergency care to uninsured patients who are OHIP eligible

645. Current EDAFA formulas only count OHIP insured patients in calculating hours of coverage at each EDAFA. As a result, emergency care provided to OHIP eligible patients without valid heath cards remains unfunded, but cannot be refused or deferred by the physician, as is possible in other settings (indeed, uninsured patients have reported that

other settings directed them to the ED for this very reason).[370] The failure to count these patients in the funding formula contributes to longer wait times, ED overcrowding and physician burnout, as there are not enough funded physician hours to meet the needs of these additional patients. Allowing OHIP eligible (but without valid health cards) to be counted as part of the EDAFA formula would allow physicians to be funded for care provided to these patients. Capturing these volumes could be complemented by the introduction of a placeholder health card number that could be shadow billed under the EDAFA group numbers or be billed FFS at the non-EDAFA EDs.

d) Establish an Emergency Department Task Force

646. The OMA is also proposing the establishment of an Emergency Department Task Force including membership from the section of EM as well as Ontario's Health Emergency Services Advisory Council ("ESAC"), dedicated to addressing the ED crisis. This table would operate on an ongoing basis, including throughout the PSA negotiation process, and would be responsible for providing advice on long-term solutions to address the ED crisis.

647. Addressing the current ED crisis in Ontario requires both short- and long-term solutions. As well, both parties will need to account for unique challenges faced by small and rural hospitals as well as large urban sites.

648. At a minimum, this task force could be responsible for:

- Reviewing programs in place that currently support coverage and service in rural and remote communities to ensure incentives and objectives are aligned
- Undertaking a review of the locum programs with the aim of reducing reliance on EDLP and TLP by stabilizing local coverage

[370] Indeed, the Health Minister has herself suggested that uninsured patients seek care from emergency departments): See, Liam Casey, Canadian Press, "Other programs can help uninsured, Ontario health minister says as coverage to end | Globalnews.ca" (March 27, 2023), TAB 217 BOD VOL 8.

- Identifying incentives needed to encourage ED groups to maintain maximum hours of coverage
- Identifying services that are utilized by OHIP eligible but uninsured patients in EDs

E. TARGETED FUNDING FOR NEW BURDEN-BASED HOCC SYSTEM

649. Under the 2021-24 PSA, the parties agreed to jointly design a new burden-based Hospital On-Call Coverage ("HOCC") program.

650. The new burden-based system was to be based on recognized levels of call intensity, modelled on the following recommended different levels of intensity:

> Level A: Attending physician required to be on site for the entire on call period for both in-patient services and the Emergency Department (in common language, 'in-house call')
>
> Level B: Attending physician responding to hospital calls, both urgent and non-urgent for both in-patient services and the Emergency Department, from an off-site location with high potential for in person attendance to provide urgent patient services (in common language, 'home call with possibility of conversion to in-house')
>
> Level C: Attending physician responding to hospital calls, both urgent and non-urgent via any means of communication (telephone, video, asynchronous communication) from hospital staff, residents or other physicians, with low likelihood to come to hospital (in common language, 'home call only')
>
> Level D: Attending physician responding to hospital calls, non-urgent via any means of communication (telephone, video, asynchronous communication) from hospital staff, residents or other physicians, with very low likelihood to come to hospital (in common language, 'call-in only')

651. Under the 2021-24 PSA, the parties agreed that the government's moratorium on funding new HOCC groups would be lifted. As a result, over the last year, the parties reviewed and approved 285 new HOCC groups and 13 Community Palliative On-Call groups, providing new funding of $19.7 million into the existing on-call program, as Phase I of its work.

652. As Phase II of its work, the HOCC Working Group has invited current and new HOCC groups to apply for the new burden-based system. A total of 3,187 applications were received by December 2023. The HOCC Working Group is currently reviewing new groups eligible under the existing program, the funding for which has been provided as part of the Year 3 Agreement by the Parties. The remaining work for the HOCC Working Group is to evaluate the applications for the new burden-based system and to fund eligible groups.[371]

653. The OMA estimates that at least $100 million dollars in new funding will be needed to implement this new program. This is about $25 million dollars more than was anticipated in the 2021 PSA, in large part because the number of newly eligible HOCC groups has increased by 285, significantly more than was anticipated at the time of last agreement.

654. In addition, the mandate of the HOCC Working Group as agreed to under the 2021 PSA was limited to developing a burden-based model for the HOCC program. Other on-call programs including Community Palliative On-Call as well as Long Term Care Home Physician On-Call and Complex Continuing Care have not been reviewed as part of this process and these programs are at risk of falling out of relativity with the HOCC program. The OMA estimates an additional $10 million dollars will be required for these other on-call programs.

I. OMA PROPOSAL

1. *$100 million dollars in targeted funding for the new burden-based HOCC system, to be implemented as soon as possible and no later than April 1, 2025.*

[371] The HOCC WG has developed a website that includes FAQ and other information relevant to the applicant groups at https://www.oma.org/member/negotiations-agreements/psa-committees-and-working-groups/psa-implementation-working-groups/.

2. *The HOCC Working Group will make recommendations to the PSC on eligibility and funding for non-HOCC on call-programs (CPOC, POC and CCC) to ensure these programs are sustainable and able to recruit needed physicians, as well as being competitive with enhancements made to the HOCC program, which the OMA has costed at an additional $10 million.*

3. *In addition, the HOCC Working Group will make recommendations on an annual basis for new HOCC, CPOC, POC and CCC groups or for bona fide expansion of existing groups.*

F. TARGETED FUNDING FOR APPs

I. BACKGROUND

655. Alternate Payment Plans (“APPs”) provide an alternative to the traditional fee-for-service model. APPs are intended to provide income stability, maintain service levels, and serve as an effective tool in recruiting and retaining specialists in practices where the traditional fee-for-service payment model is not appropriate and does not properly reflect the work performed.

656. In recent years, the province has witnessed a surge in Expression of Interest (“EOI”) requests (68 EOIs in 2022 vs 20 EOIs in 2015), which highlights both the desire and the need for the expansion of alternate payment models.

657. There are currently approximately 280 APPs in the province, with total expenditure of approximately $1.57 billion.

658. Many of the existing agreements have been in place for a long period of time (e.g., Northern Specialist Agreement in 2008, Regional Consulting Pediatrics Agreement in 2007) but have not been reviewed to ensure they continue to meet the changing needs of patients, physicians, and the communities they serve.

659. Many APP arrangements are in dire need of repair and modernization, as funding levels agreed to at the time that these APPs were developed are no longer competitive or reflect current realities. Many of the APPs were to be reviewed periodically by the parties (e.g., Academic Health Sciences Agreement, Care of the Elderly Agreement etc.) to ensure they continued to be appropriate to their circumstances, but, generally, these reviews have not occurred. This deficiency must now be addressed to ensure the vitality and viability of those plans.

660. In general terms, growth and expansion of APP agreements is a critical priority that must be addressed through the 2024 PSA. As of October 2023, there are a total of approximately 120 EOI submissions to the ministry requesting expansion of current APPs

or establishment of new agreements. These requests are expected to continue as APPs must expand in response to the growing demand for medical services.

661. Accordingly, the OMA is proposing measures for the repair, modernization, and expansion of existing APPs; introduction of new APPs; and continued work to design and implement APPs from the 2021 PSA.

662. Targeted funding is required to be allocated to address each of these areas, as described more fully below.

II. APPs under the 2021-24 PSA

663. Under the 2021-24 PSA, the parties agreed that up to $50 million dollars would be targeted for additional permanent funding for new APPs and for expansion of existing APPs.

664. To this end, the parties agreed to establish a joint working group to evaluate and determine the incremental additional cost of proposals for new APPs, and of proposals for adding physicians into existing APPs, for the purposes of allocating the funding set out for APPs under the terms of this agreement.:

- The changes in demand for physician services under the APP (volume and acuity)
- Wait times and changes in wait times over time
- Alignment with hospital volume projections
- Changes in practice and new technologies
- A multi-year HR plan for the Group
- Alignment with clinical needs
- Alignment with community needs
- Sustainability and appropriateness of current compensation model

665. As per the terms of the 2021-24 PSA, the parties developed a bilateral process to evaluate APP proposals incorporating criteria outlined in Section C of the 2021-24 PSA

which was used to consider and prioritize APP requests submitted pursuant to the 2021 PSA. Continuation of this structured process into 2024 PSA and beyond is essential to enable the parties to objectively evaluate APP requests using mutually agreed criteria.

666. The parties also agreed to establish a Hospitalists APP with a Hospitalist Medicine APP Working Group to design a Hospitalist Medicine APP for intended implementation by April 1, 2023. Due to the complexity of the undertaking, the working group has not been able to complete this task by the end of the 2021 PSA. The working group is meeting monthly to derive a viable model in consultation with relevant stakeholders and continue to make progress. The Physician Services Committee has agreed to extend the work until October 2024.

667. Furthermore, the parties agreed to various targeted APP repair and other initiatives aimed at specific APPs, above and beyond the funding committed for the above initiatives, including for London Neurosurgery APP, the Northwest and Northeast Regional Surgical Networks, the Ontario Telestroke Program, and the Rural and Northern Physician Group Agreement ("RNPGA"), as well as to establish a new APP for Vascular Surgeons. The work on the above APPs has now been completed.

668. Furthermore, the parties also agreed to continue work on implementing a new Laboratory Physicians alternate funding model (work which is still ongoing), a permanent AFP model for Genetics, Infectious Disease and Geriatrics. These APPs have not yet been concluded and there still may be outstanding disputes arising out of the 2021-24 PSA.

III. OMA Proposal

a) Repair, Modernization and Compensation Increases in Addition to Normative Increases to Existing APPs

669. The OMA proposes $40 million dollars in targeted funding over the life of the 2024-28 PSA ($10 million dollars for each year), with the funding to be allocated in the following manner:

1. *Establish a bilateral APP Repair Working Group reporting to the Physician Services Committee. The APP Repair Working Group will be tasked with:*

    a. *Developing and applying evaluation framework to prioritize APPs requiring repair/modernization;*

    b. *Calculating the cost of repair and modernization using agreed upon methodology; and*

    c. *Recommending for implementation to PSC specific agreements reached by the Working Group throughout the course of the PSA.*

2. *The OMA also proposes a comprehensive review of the APP agreements listed below, with a mandate to make recommendations for enhancements and modernization of the agreements. The OMA is proposing a working group to be established for each of these agreements:*

    a. *Care of the Elderly Agreement*

    b. *Northern Specialist APP*

    c. *Provincial Trauma Team Lead APP*

    d. *Regional Consulting Pediatrics APP*

It is to be noted that this proposed funding does not include repair costs for EDAFA or the academic funding agreements (pediatrics and AHSCs generally), which are the subject of separate proposals below.

b) Introducing New APP Agreements and Expanding Existing APP Agreements

670. Demand for health care services continues to grow. However, funding for many APPs is fixed based on the number of FTEs approved under each agreement.

671. To recruit new physicians necessary to meet increasing patient demands, physician groups must submit requests and receive approval from the Ministry for additional human resources before they can expand to meet clinical needs. This is often a difficult and time-consuming process and funding to allow for expansion may not always be available. In the past, the Ministry would either approve, deny or partially approve such expansion requests, often without providing the OMA or physician groups with a sound (or even any) rationale for its decision. A more systematic and transparent process was required to assess expansion applications from APP groups.

672. As per the 2021 PSA, a robust joint process has been developed to assess and respond to expansion proposals more systematically. The OMA proposes that the bilateral group finalizes the evaluation criteria as per the 2021 PSA and the working group review these requests bilaterally using the agreed upon evaluation criteria. To implement changes agreed to by the parties through the joint process, dedicated funding to permit APP expansion and new APPs (including the agreed commitment for a new addiction medicine funding model and Hospitalist Medicine APP) must be provided.

673. The OMA proposes a $50 million investment in the first year of the PSA and an incremental investment of $30 million in each subsequent year of the PSA to enable the growth of current APPs and the establishment of new APPs.

674. Again, it is to be noted that this funding excludes expansion and growth of EDAFAs as well as the academic funding agreements (pediatrics and AHSCs generally), which are the subject of separate proposals below.

c) Amend Current Oncology Agreements

i) Background and Rationale for proposal

675. The Provincial Oncology AFP ("POAFP") has undergone restructuring in the past few years to allow independent governance of each specialty, with the original agreement now split into three separate agreements for radiation oncology, medical oncology and gynecological oncology. Through this process, it was recognized that the terms of separate agreements have not been reviewed and amended for over a decade. As a result, the OMA proposes the changes outlined below.

ii) Radiation Oncology – Funding for Peer Review

676. The technological revolution in radiotherapy planning and delivery that emerged over the last 15 to 20 years and which continues to develop has improved patient outcomes with greater treatment intensity and precision. It has also enhanced system capacity and patient convenience with much shorter overall treatment times. The widespread adoption of these highly complex and intense radiation treatment plans has increased the risk of error in radiation planning and delivery compared to earlier, simpler techniques.

677. Peer Review of radiation treatment plans is now accepted as the most effective way to mitigate these risks and is considered best practice in most jurisdictions that employ modern radiotherapy.

678. Indeed, Ontario Health-Cancer Care Ontario ("OH-CCO"), in its oversight role for radiation therapy quality assurance in Ontario has issued practice guidelines establishing peer review as a standard of care[372] and as a collected quality metric with minimum specified acceptable activity standards. Peer review is conducted in each Regional Cancer Centre as a scheduled weekly or more frequent multidisciplinary (Radiation Oncology, Therapy, Medical Physics) group event where all proposed complex treatment

[372] Cancer Care Ontario, *Recommendations for Radiation Peer Review*, (May 2021), TAB 218 BOD VOL 8.

plans are presented clinically. Such plans are displayed visually, critiqued, and required changes recorded, allowing the optimization of treatment. All physicians participate in sessions related to their disease site. These meetings can be held virtually and regionally for rare diseases, where a single centre cannot meet a quorum for an effective meeting. OMA billing data (Interactive cost analysis FY2017-8) demonstrates that 43,221 treatment plans were undertaken by Radiation Oncologists in that fiscal year and that 39,785 (92%) qualified for Peer Review.

679. While Peer Review was noted as a possible future accountability under the POAFP in 2015, as it was not a current accountability at the time, no funding was provided under the POAFP for such activities. Despite the fact that it is not a funded activity under the POAFP, the practice of conducting Peer Review across Ontario centres has developed into, in effect, an uncompensated accountability since 2015.

680. Radiation Oncologists have experienced a time burden providing Peer Review clinical services that is growing in tandem with the modern transformation in radiotherapy care. Even in 2018, a province wide review of practice survey[373] established that Radiation Oncologists were spending an average of 3.8 hours per week engaged in peer review. This time burden will only grow with next generation of improvements in radiation planning and delivery. Ongoing research that expands the indications for high-precision radiotherapy will also add to this burden. The current unfunded model is inequitable, unsustainable and needs to be urgently addressed.

iii) GYNECOLOGY ONCOLOGY

681. Systemic therapies administered by gynecologic oncologists are becoming increasingly complex, and many more patients are on targeted therapies (such as Parp-inhibitors and immunotherapy). Overall, patients are increasingly complex and unwell, with more comorbidities and more lines of therapy, and their visits require more time and more comprehensive work-up. Similarly, the extent and complexity of gynecologic

[373] OMA Radiation and Oncology Section, “Call for New Data for Purpose of Relativity Calculation in the CANDI Model,” (November 30, 2018), Survey Results, and Appendix G, Survey Questions and Appendix E, Survey Results Data, TAB 219 BOD VOL 8.

oncology surgeries and post-operative care has increased since the gynecology oncology APP was implemented. Gynecologic oncology surgeons are increasingly performing more complex procedures to achieve optimal surgical outcomes for patients with gynecologic malignancies. In 2021/22, gynecologic oncology surgeons performed 61.3% more low rectal resections, 50% more splenectomies, 23% more ileostomies than in 2014/15.

682. As gynecology oncology is not an OHIP recognized medical specialty, gynecology oncologists submit shadow billed claims under the Obstetrics & Gynecology specialty. Given the current methodology for applying flow through to each APP agreement, this has resulted in a significant disparity in the value of shadow billing premiums amongst oncologists, with gynecology oncologists receiving 33% premium on shadow billed claims while their colleagues in medical oncology APP receive 61% premium on shadow billed claims.

iv) NEURO-ONCOLOGY

683. Central Nervous System oncologists are represented by two professional groups:

- Neurologists who have Central Nervous System specialty training and are referred to as “neuro-oncologists”, and
- Medical oncologists who have Central Nervous System subspecialized training and are referred to as “medical neuro-oncologists”

684. Ontario is particularly dependent on the efforts of the neuro-oncologist group who direct the care of about 80% of patients in the province who have a primary brain tumour. Neuro-oncologists commonly serve as the most responsible physician for patients undergoing adjuvant therapy for a primary brain tumour, and in this role, they oversee treatment with systemic therapies, manage seizure and complications of disease and treatment, and offer patients guidance with medical decision-making.

685. The majority of medical oncology practitioners, including medical neuro-oncologists, are remunerated for their work with cancer patients through a POAFP. The

POAFP recognizes the complexity of the services they provide, the importance of teaching and research to advance high quality cancer care for Ontarians and support a sustainable workforce.

686. The POAFP, however does not extend to neuro-oncologists, who instead depend heavily on FFS billings, which does not provide equitable income commensurate with their clinical workload compared to their medical neuro-oncologists colleagues. Indeed, this inequity in funding has contributed to recent loss of neuro-oncologists at Hamilton and Trillium Health Sciences.

v) OMA Proposal

687. As a result, the OMA proposes as follows:

1. *Radiation Oncology*
    a. *Peer review be included as an essential service and receive appropriate renumeration through the existing Radiation Oncology APP*

2. *Gynecology oncology*

    a. *Shadow billing premium to be increased from 33% to 50% due to increasing complexities of the systemic therapies;*
    b. *Increased funding for fellows, clinical associates and non-APP oncologists.*

3. *Medical oncology/Neuro oncology*

    a. *Neuro-oncologists to be either added as a separate physician group under POAFP, or to develop a new APP for Neuro-oncology that offers the same compensation as the Medical Oncology AFP.*

An estimated $15 million will be required to address these oncology changes ($1.3 million for gynaecologic oncology, $12 million for peer review based on $52.2 k per FTE, and $1.8 million for Neuro Oncology).

d) Address the Needs of Children's Hospital APP Agreements

i) HOSPITAL FOR SICK CHILDREN

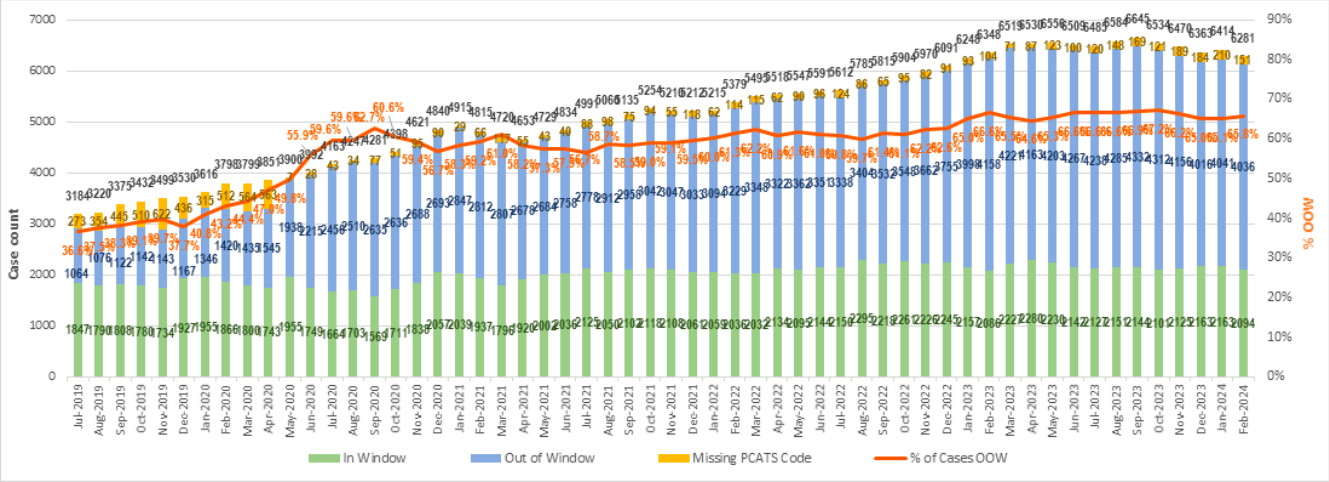
688. The Hospital for Sick Children ("SickKids") is a tertiary and quaternary medical and surgical care provider serving a vital role in the care of the paediatric patients across Toronto and the province. It is the referral centre for all quaternary (and >50% tertiary) cases for the province and across Canada. Indeed, SickKids is Canada's most research-intensive hospital and the largest centre dedicated to improving children's health in the country.

689. The medical provider groups in the AFP are divided into surgical/anesthesia and pediatric/medical specialty groups, which work together closely, and the challenges facing each are described below.

690. **Surgery and Anesthesia**: As a quaternary centre and the designated paediatric trauma centre for Ontario, SickKids surgeons and anesthesiologists are among the best in the world at quaternary clinical care and academic advancement. Quaternary care includes complex medical and surgical interventions as well as experimental treatments and procedures, many of which are only available at Sick Kids.

691. The lack of anesthesia and surgeon resources can be readily seen in the growing waitlists and delayed treatment for procedures and surgeries. It is important to realize that the waitlists were growing significantly for the past decade, exacerbated by the reduction in elective surgeries during COVID-19.

692. As of January 8, 2024, there were 6,414 children on the SickKids surgical wait list with 65.1% of these children waiting longer than clinically recommended for surgeries:



693. There were 79 children waiting longer than 2 years for surgery, pre-COVID and the number has increased to 1,860 as of January 8, 2024. In addition, children waiting longer than 1 year for surgery, has also increased by 1,910.

694. Over the past few years, SickKids has lost three of the top world-wide paediatric cardiac surgeons (including both University of Toronto, Departmental and Divisional Chairs) to US centres for more competitive remuneration. SickKids has also lost general surgeons, urologists, orthopedic surgeons, neurosurgeons and plastic surgeons in the prime of their careers who are extraordinarily difficult to replace. For example, two of three cardiac surgeons were replaced by junior/early career surgeons which is a threat to the cardiovascular surgical program's skill-set which takes decades of experience to reach world-class standards. Junior faculty recruitment has particularly impacted the surgical fields and anesthesia, where a majority of resident training occurs in adults, and these young doctors then choose not to pursue subspecialized training and careers in paediatrics.

695. Canada has not been spared from the global shortage of anesthesiologists. Competition for paediatric anesthesiologists is even more intense, and this is truer still for paediatric sub-specialized fields like cardiac anesthesia and pain medicine. Training for paediatric sub-specialized anesthesia is a ~15-year runway, and these are the individuals for whom SickKids must compete to recruit as the tertiary and quaternary children's hospital for the city, province and country. In contrast, anesthesia training for the

community is a 12-year runway, and so the training period is shorter, the patient complexity and stress is lower, and the remuneration is significantly higher. More broadly it is critical that SickKids is able to offer competitive remuneration to highly skilled and experienced surgeons, anesthesiologists and paediatric sub-specialists.

696. **General and subspecialty paediatrics**: For pediatric subspecialists, lower remuneration has resulted in the inability to compete with other provinces, the community, and other countries (mainly USA and EU). The Department of Paediatrics has endured the resignation of significant numbers of its physicians over the last few years, many leaving for lateral moves due to compensation, and not leadership opportunities. Although these resignations occurred in almost all of the 18 Divisions, the greatest number of resignations, ranging from 30% to over two-thirds of divisional FTEs, occurred in four sub-specialties: Adolescent Medicine (includes eating disorder specialists), Cardiology, Neonatology, Neurology, Clinical & Metabolic Genetics, and Nephrology. Our faculty are thus highly sought after by other Centres; the successful recruitment of paediatric physicians into these sub-specialties remains extraordinarily difficult at both junior and especially mid-career levels due to the current starting salaries in Paediatrics. As well, many experienced paediatric subspecialists are being replaced by new or very junior physicians resulting in significant loss of expertise and experience. The added burden of recruiting in a high-cost-of-living geographical area decreases the ability to attract the best and brightest which is always SickKids' objective.

697. Across SickKids in both the surgical and paediatric groups, both mid-career and later career physicians are leaving in increasing numbers, and many are leaving for greater remuneration elsewhere, including for the ability to earn substantially more in the community and elsewhere. Over the last five years alone in the paediatric specialties, there have been 38 departures (an increase of 46% over the previous five years), with the overwhelming majority being mid-career or mid to later career.

698. The funding mechanism for SickKids' physicians is the Hospital for Sick Children Alternate Funding Plan ("HSC AFP"). This funding mechanism has long recognized the inappropriateness and inadequacy of fee for service for the physician services provided

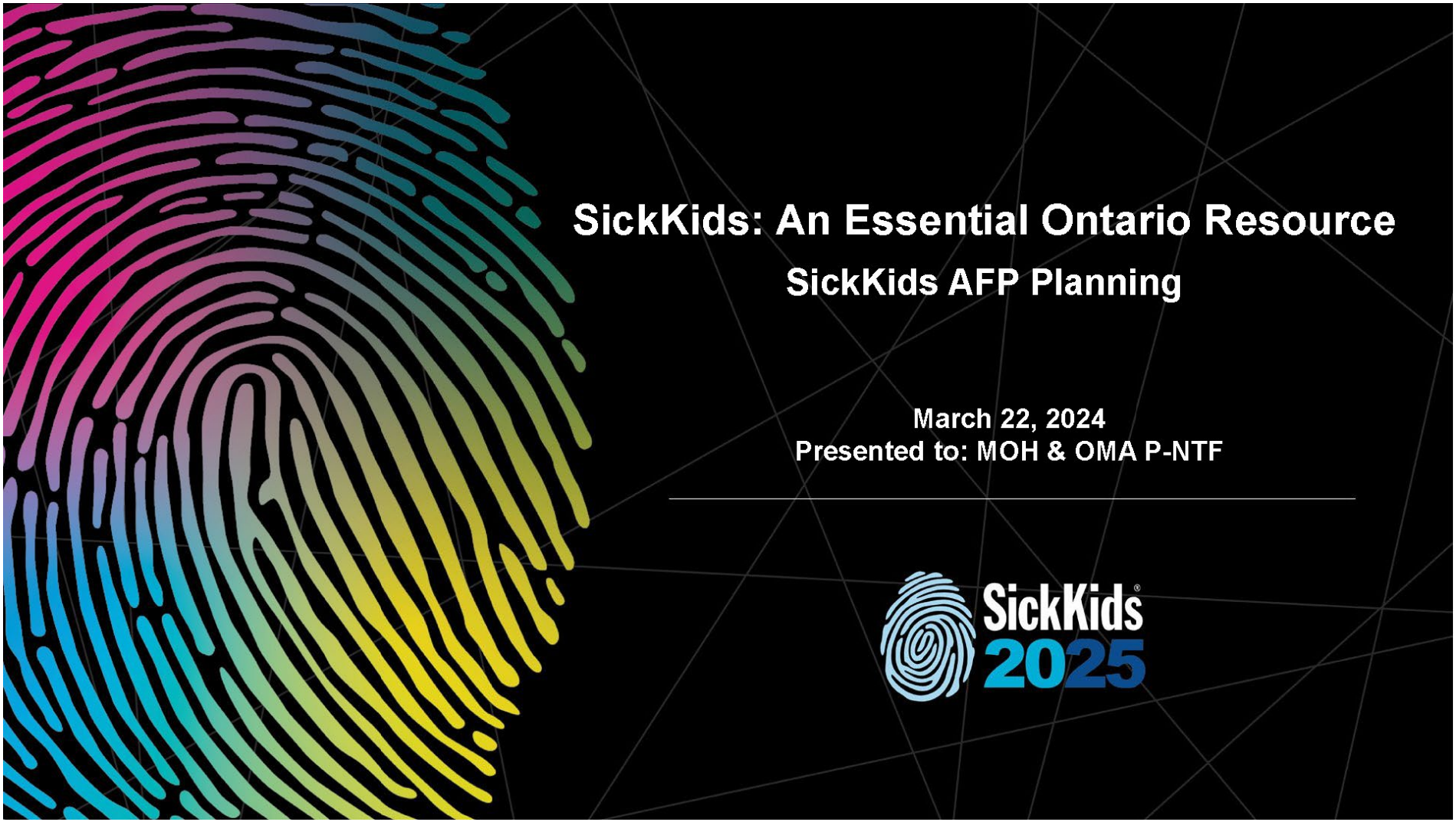
at SickKids. Originally designed to competitively fund academic medicine 16 years ago, the 2007 AFP initially brought total funding available to SickKids physicians to approximately the 75th percentile of all (equivalent specialty) full-time physicians' professional billings. This base funding at the time allowed for ease of recruitment and retention that created excellence in clinical service and led to world-renowned academic contributions across disciplines.

699. However, while the AFP received flow through increases in 2009, 2010 and 2011, it was subject to consecutive decreases in 2013 (twice) and an imposed decrease in 2015, which was subsequently reversed in 2020/21.

700. Thereafter, SickKids has received no further increases, apart from the Kaplan Arbitration Award and flow through resulting from the 2021 Physicians Services Agreement. With only these modest increases, current funding levels have fallen well below the 75th percentile of equivalent community specialists.

701. As noted above, this has led to significant challenges with recruitment and retention. Inadequate compensation levels not only affect retention, but has also affected junior level recruitment, where compensation on start-up for these physicians and surgeons leads many to exclude SickKids as a career choice.

702. The following slides set out the OMA's proposal to improve compensation for SickKids physicians. There is a pressing need for improvements to funding and compensation for physicians in The Hospital for Sick Children's AFP.


SickKids: An Essential Ontario Resource
SickKids AFP Planning
March 22, 2024
Presented to: MOH & OMA P-NTF
SickKids
2025

AFP: Considerations for AFP Renewal

Part A:

1. Why SickKids is Unique
2. Complexity at SickKids
3. Physician Retention & Recruitment
4. Advanced Paediatric, Surgery and Anesthesiology Training

Part B:

5. Overview of our AFP 'ask'

Why are Paediatrics and SickKids Unique

Ranked #2 World's Best Specialized Hospitals 2023

- Fee for Service is not adequate for paediatric academic centres
- Highest patient acuity and complexity
- Province-wide paediatric and surgery tertiary care
- Highly trained and experienced subspecialty paediatricians, surgeons, anesthesiologists, and psychiatrists
- World class research productivity
- Advanced paediatric, surgery and anesthesia subspecialty training

Unique Programs, Services, and Procedures at SickKids

- SickKids provides 54% of all paediatric tertiary and quaternary surgical care in ON
- 33% of its inpatient resources dedicated to children who were transferred to SickKids from other hospitals, including those with paediatric subspecialty programs
- SickKids is experiencing an increasing trend in the number of patients from other parts of Ontario (and out of province)
- SickKids provides near exclusivity in many highly specialized, medically, and surgically complex programs and procedures (350+ unique programs/services/procedures)

Complexity at SickKids and Systems Role

Complexity:

- Large volume medical and surgical practice, PLUS highly complex
- Rare disorders with unique expertise, that cannot be looked after elsewhere
- Provide most up-to-date and innovative care in the country

Systems Role:

- Leading and championing access to paediatric medical and surgical care
  - Coordination of surgical wait lists and paediatric access across the GTA

World Class Research Productivity and Innovation

- SickKids is #2 most research-intensive hospital in the country
  - SickKids is #1 most research-intensive paediatric hospital in Canada

- AFP has enabled world-leading innovation in care and research benefiting children in Ontario and worldwide

- Enabling discovery and innovation that pushes the frontiers of paediatric care, ensuring Ontario children experience ground-breaking advancements, first

Background for SickKids AFP

- SickKids AFP includes two independent groups with their own structures and needs:
  - **“Paediatric Specialties Association”**
    - Surgical disciplines, anesthesia, critical care medicine and psychiatry
  - **“Paediatric Consultants Partnership”**
    - Paediatrics [general pediatricians and pediatric subspecialists]
- Last contract 2007

SickKids AFP Divisions

Paediatrics (PCP)

18 Divisions

Adolescent Medicine
Paediatric Medicine
Neurology
Cardiology
Nephrology
Paediatric Emergency Medicine
Paediatric Dermatology
Haematology-Oncology
Clinical Pharmacology & Toxicology
Clinical and Metabolic Genetics
Respiratory Medicine
Cardiology
Rheumatology
Gastroenterology, Hepatology & Nutrition
Endocrinology
Immunology & Allergy
Neonatology
Developmental Paediatrics (Bloorview)

Paediatric Specialties Association

Cardiovascular Surgery
General and Thoracic Surgery
Orthopaedic Surgery
Neurosurgery
Plastic and Reconstructive Surgery
Urology and Transplant Surgery
Anesthesia and Pain Medicine
Critical Care Medicine
Ophthalmology and Vision Sciences
Otolaryngology, Head and Neck Surgery

Psychiatry

Recruitment and Retention

- Growing crisis in resignations [>20% loss to other Centres]
- Replacing highly experienced physicians and surgeons with just-trained faculty
- Limited pool of highly trained candidates [locally, nationally, internationally]

Recruitment and Retention Crisis [Surgery]

- Surgeons and anesthesiologists first train specializing in adult care, and then after completion of formal adult training, they obtain further training in paediatric surgery and anesthesiology

- Surgeons and anesthesiologists preferentially strongly favour jobs in adult practice where remuneration is higher and thus forego paediatric subspecialization

- Advanced technical skills required at SickKids are extremely challenging to replace

- Recent departures of highly skilled surgeons and anesthesiologists to the US for better compensation

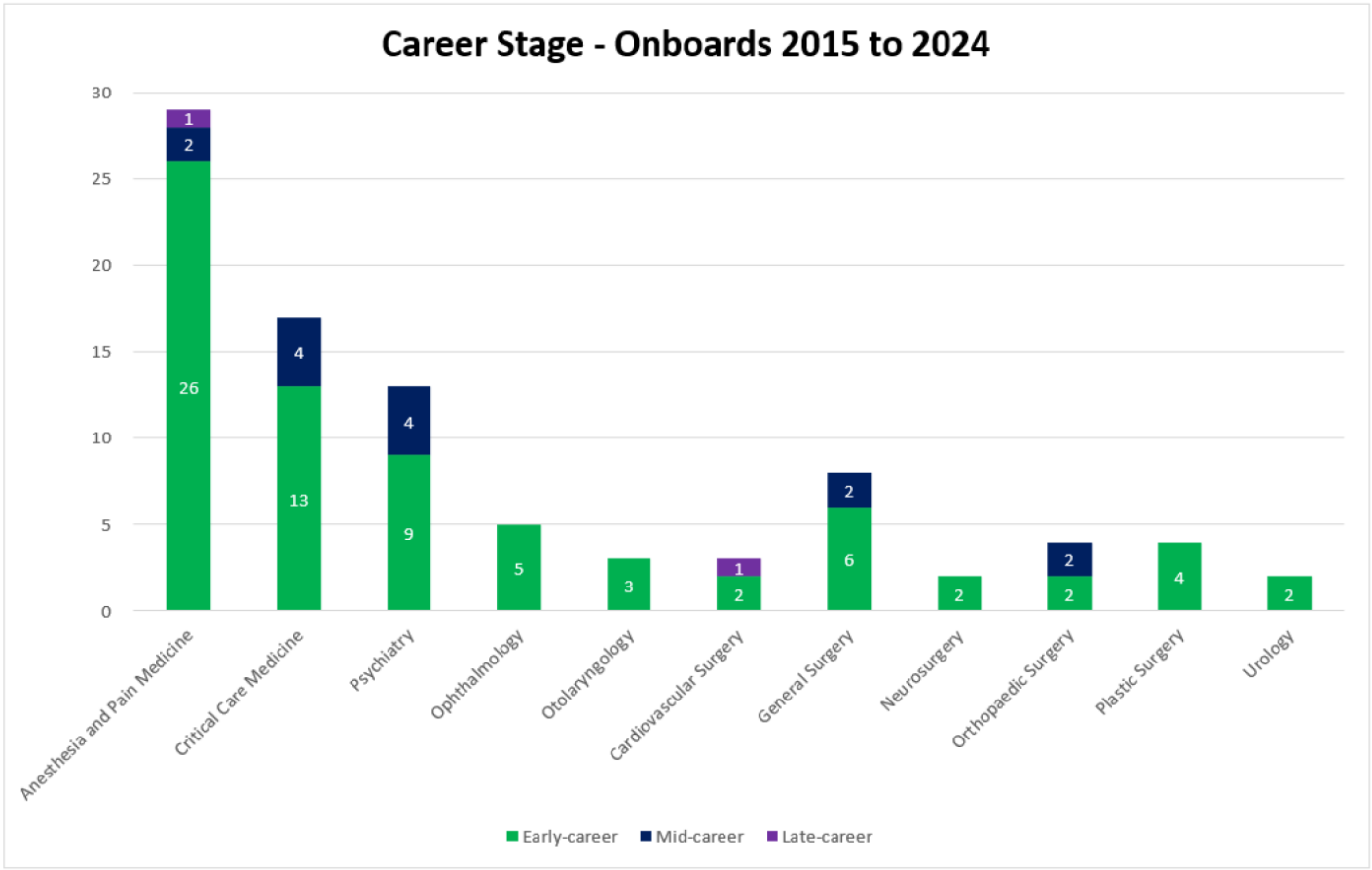
Recruitment & Retention Crisis [Surgery]

MORE EXPERIENCED PHYSICIANS ARE REPLACED WITH LESS EXPERIENCED PHYSICIANS

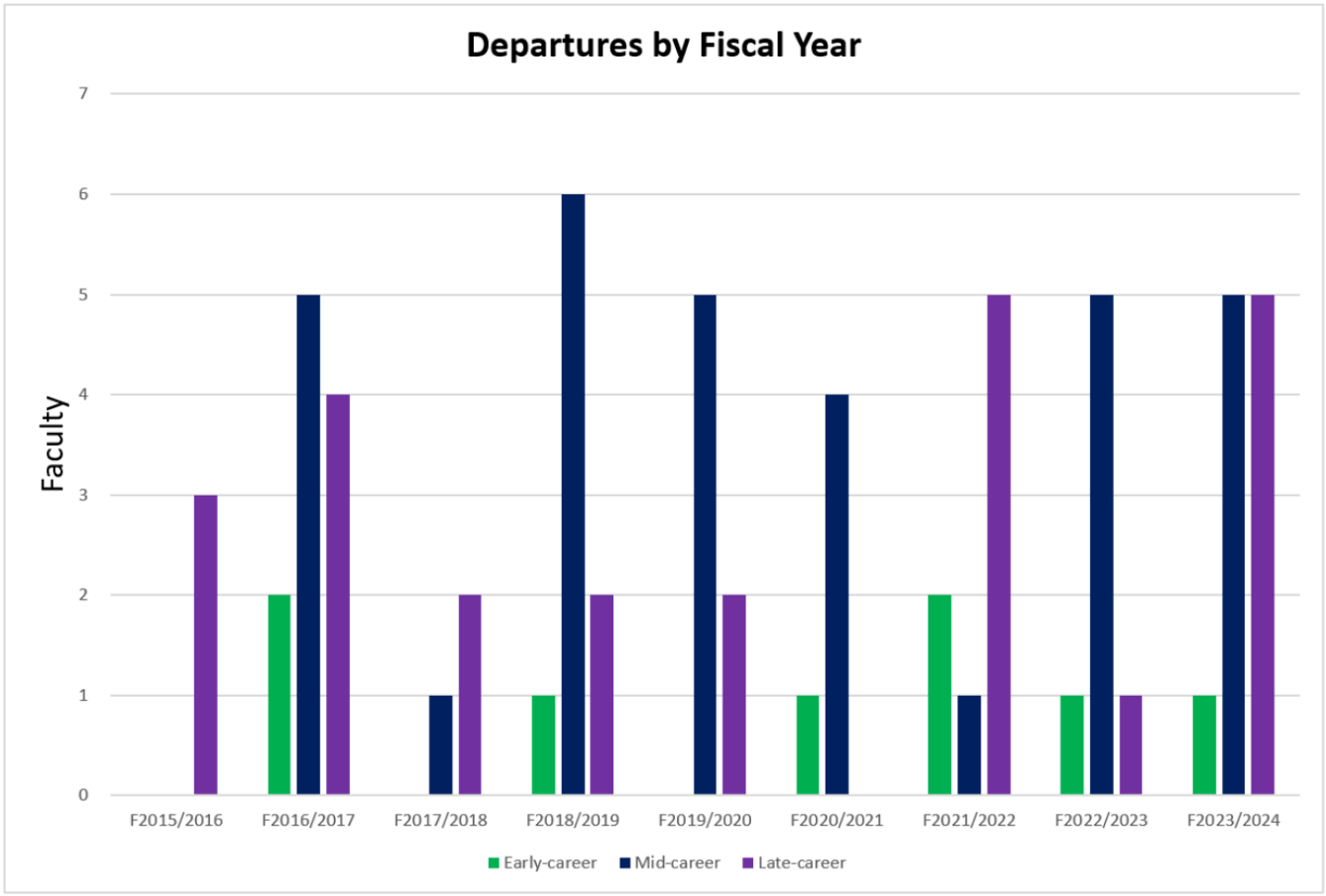
Departures since 2015 – a 10-year snapshot

- All departures left for opportunities for greater remuneration
- 41% were recruited to major US Hospitals
- 46% increase in departures in last 5 years over previous 5 years

And are being replaced by almost exclusively ‘just-trained’ [Surgery]



Departures are mostly mid/late career…. [Surgery]



Paediatrics Recruitment and Retention Crisis

MORE EXPERIENCED PHYSICIANS ARE REPLACED WITH LESS EXPERIENCED PHYSICIANS

- **Increasing resignations (18%) - across almost all subspecialties**
  - 60% Division Head Leaders turnover
- **Comparing Turnover Rates (Paediatrics)**
  - Resignation rates: **SickKids 18% vs. 2-5% for 2 Canadian peers**
- **Pool for recruitment exceptionally low**
  - Decline in trainees choosing subspecialties across N America
  - 2023 subspecialty graduates in Ontario only 31 (for ALL specialties)

Paediatrics Recruitment and Retention Crisis

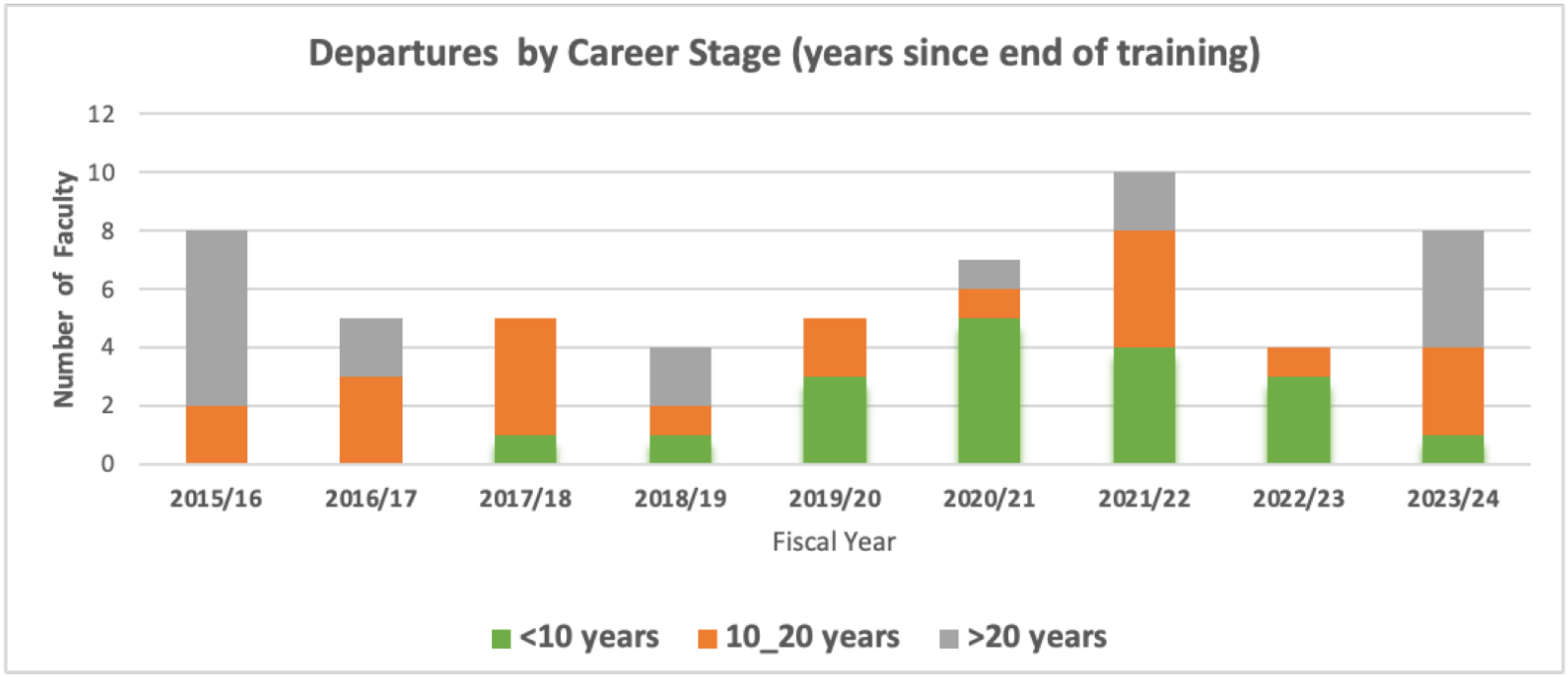
Why?

- Inability to compete with salaries: other provinces (Alberta), and countries (US)
- GTA cost of living significant limiting factor

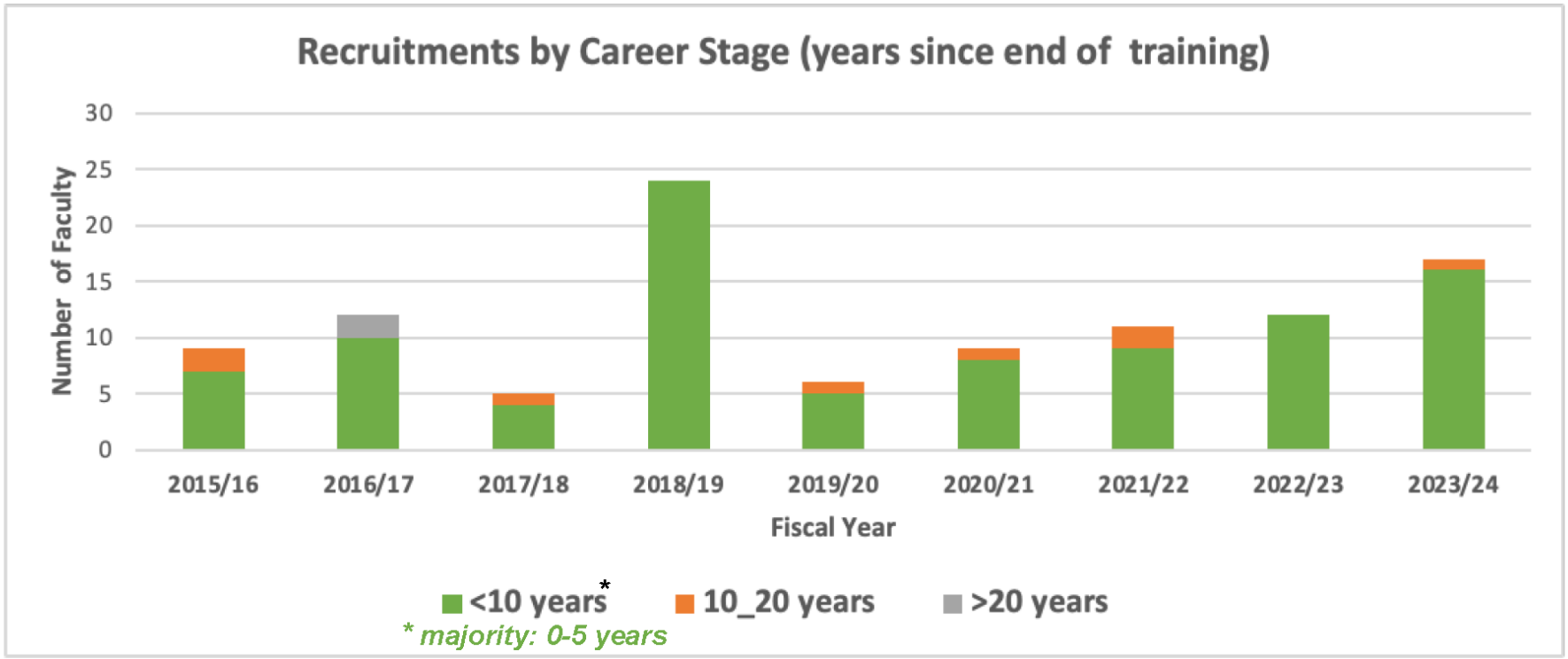
Where are faculty going when they leave SickKids?

- **Snapshot : N= 48 departures (>10 years of data)**
  - **40/48 - lateral moves**: 17/40 US/International academic centers; 8/40 out of province, 15/40- community/other ON

Paediatrics Departures are mostly mid/late career….



And are being replaced by almost exclusively 'just-trained' [Paediatrics]



Repair to the 75th percentile

Requesting to be re-calibrated to remuneration levels in 2007:

- ✓ aligned to percentiles external to SickKids for relevant competitive specialties
- ✓ tagged to adult competitive subspecialty percentile levels

75th percentile funding enabled the following:

- ✓ Market competitive compensation
- ✓ Recruitment and Retention
- ✓ Created sustainability of excellence in new and existing clinical services
- ✓ Maintained critical mass of diverse subspecialty expertise
- ✓ Led to world-leading research discoveries and clinical implementation in paediatrics and surgery

Breakdown of Repair to achieve 75th percentile

Paediatric Specialties Association (Surgery, Anesthesiology, Critical Care)

*141.05 FTEs – total to achieve 75th %tile = **$17,929,368**

+ new business cases of 2.80 FTEs (2018) + 27.55 FTEs = **$3,364,274**

Total for Paediatric Specialties Association = $21,293,642

Paediatric Consultants Partnership (Paediatrics)

*217.10 FTEs – total to achieve 75th %tile = **$38,401,644**

+ new business cases of 25.5 FTEs = **$5,003,943**

Total for Paediatric Consultants Partnership = $43,405,587

***Represents data from Fiscal 2022/23**

Elimination of Flow Through

Proposal:

- To eliminate the current flow-through methodology and replacing it with a model which calibrates target rates by specialty using 75th percentile benchmark
- A change in flow-through is required to maintain a level of compensation equal to the 75th percentile of community counterparts

Background:

- Prior Physician Services Agreement adjustments were intended to ensure that compensation increases kept pace with other physicians in Ontario

- Current methodology for calculating flow-through adjustments resulted in a widening of the compensation gap between community physicians and those practicing at SickKids

Elimination of Fee for Service (FFS) Conversion

Proposal:

- Eliminate FFS conversion – methodology is no longer relevant
- MOH to increase the notional rate for each specialty at the time of recruitment
- Ensure new recruits are funded the same rate as existing physicians

Background:

- FFS conversion dates back to early 1990s
- Purpose was to track conversion amounts between FFS and non-FFS pools

Establish Expansion Fund

Proposal:

- Establish an expansion fund of 5% (~$3.25M) of the AFP contract value
- Fund will provide stable funding to recruit new physicians
- Establish an agreed upon process with the MOH to access funds

Background:

- Current EOI (business cases) process does not support timely expansion to meet emerging demands
- Current uncertainty around expansion creates significant risk to services

Maximizing Output for Clinical Care: Clinical Fellows & Physician Assistants

- Clinical Fellows and Physician Assistants feature prominently in our strategy to manage:
  - increasing patient complexities,
  - play a key role in the provision of quality, safe and timely care:
    - 24/7 care
    - surgical assistance in the operating room
  - Impact to timely access and response to patient care needs
- Current funding gap of $8.2M for Clinical Fellows and $2.5M for Physician Assistants (PAs)

- Requesting new funding for physician extenders (Clinical Fellows & PAs) $10.7M

Increase to Shadow Billing Premium

Proposal:

- Increase the shadow billing premium from 22.3% to 25% (<$2M)
- Proposed increase aligns with other paediatric academic centres
- Propose new accountability metrics with MOH

Background:

- SickKids physicians are required to submit shadow billing
- Does not and cannot account for the significant volume of indirect clinical care
- Schedule of benefits does not appropriately recognize the complexity of paediatrics

Adjustments to Fee for Service (FFS) Billing Threshold

Proposal:

- Provision to address special circumstances (i.e. surgical backlog)
- Permit FFS when providing paediatric care at other facilities above and beyond the full time equivalent
- Arrangements to be time-limited based on mutually agreed-upon parameters

Background:

- Currently AFP has provisions which allow physician groups to submit FFS claims for out-of-scope services to a certain limit
- Numerous collaborations at present supporting FFS to meet patient demands
- Current process for approval is not timely

Key Messaging

- SickKids provides near exclusivity in many highly specialized, medically, and surgically complex programs and procedures (requires *extra* training)

- SickKids is experiencing significant and increasing challenges with recruitment and retention

- The convergence of specialized clinical care, world-class research, and advanced training is essential to push the boundaries of paediatric medicine and surgery
  - Can only be accomplished with unique, highly trained and sub-specialized paediatricians, surgeons and anesthesiologists

- Achieving a new AFP is paramount to provide timely care for Ontarians, achieve excellence in children's health, and remain a leader in paediatric innovation for the country

Key Messaging

- SickKids is the last resort for patients that cannot be treated anywhere else in Ontario
- Expert clinical services are currently threatened, putting at risk patient outcomes and the need to go to the United States

AFP Summary and Request

	Proposal	Funding $(M)
A	Repair of HSC AFP	$ 64.70
B	Replacement of flow through methodology	-
C	Elimination of FFS Conversion	-
D	Establish Expansion Fund	proposing 5% of AFP
E	Physician Assistants and Clinical Fellows	$ 10.70
F	Shadow Billing Premium	$ 2.00
G	Adjustment to FFS Billing Threshold	-
	Total	**$ 77.40**

ii) CHAMO

Children's Hospital Academic Medical Organization AFP

703. The Children's Hospital of Eastern Ontario ("CHEO") is a critical hub for pediatric care in Canada. It is the only children's hospital within a 28,000 square kilometre area, serving 500,000 children and youth annually across Eastern and Northern Ontario – a number projected to grow significantly in coming years.

704. As the only referral centre for pediatric care for regions in Eastern and Northern Ontario, CHEO plays a unique and critical role in treating acutely and chronically ill children in Ontario. CHEO is the only pediatric hospital in the region and the only hospital that admits children outside of the neonatal period. Furthermore, there are essentially no outpatient pediatric services within the region other than community Emergency Departments. As a result, children who are turned away from CHEO must travel considerable distances to receive adequate care. If and when CHEO's capacity is strained, patients and their families have few other options. The hospital additionally serves as a tertiary trauma centre for areas of Nunavut, and the Outaouais region of Western Quebec.

705. CHEO is also home to one of only two Level I pediatric trauma centres in Ontario (along with the Hospital for Sick Children in Toronto) and is one of only seven of its kind in Canada. At present, Eastern Ontario is facing an increasing gap in access to pediatric acute care, caused by high wait times for emergency care and staff shortages in specialized program areas.

706. The Children's Hospital Academic Medical Organization ("CHAMO") funds the care that is provided by CHEO physicians through an AFP. Over the years, this funding has fallen very far behind what is needed to recruit and retain the number and types of doctors needed. At current staffing levels, CHAMO physicians are unable to provide safe care to children and youth.

707. First established in 2002, the CHAMO Alternative Funding Plan ("AFP") was last re-negotiated in 2006, with only modest adjustments made since then. CHEO now faces highly urgent capacity pressures, and a recruitment and retention crisis, that must be alleviated immediately through substantially enhanced funding to the CHAMO AFP.

708. At the time the CHAMO AFP was initially funded, the agreement was intended to bring physician compensation in a range competitive with community and academic comparators. The stable base funding offered through the AFP allowed CHAMO to attract highly specialized clinicians to provide specialized and complex care to children in eastern Ontario.

709. The CHAMO AFP received a flow-through increase in 2009, however this was associated with a 3% reduction to the AFP base. Further flow-through increases occurred in 2010 and 2011, which were followed by two consecutive flow-through decreases in 2013 and a unilaterally imposed decrease in 2015. The latter was subsequently reversed in 2020/21. Thereafter CHAMO has received no further increases, apart from the Kaplan Arbitration Award and flow through from the 2021 Physicians Services Agreement.

710. Thus, the CHAMO group has not seen a significant infusion of funding to address competitiveness or recruitment in 11 years, and the agreement as a whole has not been re-set or refreshed for 22 years. As a fully comprehensive AFP that includes all clinical and academic work, the CHAMO AFP provides the only mechanism CHEO departments have to hire new physicians. Other than funding for new recruits or limited increases through PSA settlements, the CHAMO agreement has not had changes for over 15 years and has not been significantly changed since its inception in 2002. Likewise, there has been essentially no increase in the number of funded physician positions within CHAMO for the last 5 years.

711. The failure to maintain competitive and reasonable funding for physician compensation across CHAMO has inevitably resulted in serious recruitment and retention crisis, and in severe effects on children.

712. Over years of growing AFP funding shortfall, CHAMO’s funding has become increasingly less competitive, resulting in many physicians choosing to leave CHEO for adult care, private clinics, or other pediatric institutions across Ontario and the country. Others have left for opportunities in the community, citing remuneration as the driving factor. Moreover, finding new recruits to fill these vacancies has proven nearly impossible for various specialties, with many unwilling to take on a position with high workload, aggressive call schedule, and sub-par remuneration.

713. There are a variety of key factors that explain and have contributed CHEO's recruitment and retention challenge:

- Physician allocations have not kept pace with population growth.
- The number of physicians employed by CHEO has not kept pace with regional population growth over the past decade. The CHAMO AFP was designed to fund the organization for the number of physicians that were needed to meet the region's population needs in the early 2010s. With over ten years of growth and change since then, the day-to-day clinical demands of physicians across the organization have changed significantly and will likely continue to do so as a matter of basic demographics.
- Frontline pediatric staff and clinicians have been experiencing burnout over the past few years, severely compounded by the COVID-19 pandemic and the subsequent surge in pediatric respiratory illnesses.
- Staff shortages have also contributed to the temporary shutdown of different service areas, resulting in even more delayed patient care. At CHEO, kids' surgeries have been canceled to make room for increased acute patient volumes.
- Specialized staff from different service areas have had to be temporarily redeployed into emergency, critical care, and pediatric medicine. Given the growing child and youth population of Eastern Ontario, this trade-off is not sustainable for maintaining an acceptable standard of care.
- Physicians are pursuing opportunities in higher-paying hospitals and clinical roles, resulting in departures and long-term vacancies.
- Given the impact of burnout and very low morale on physician resources (e.g., early retirements), an already difficult recruitment challenge has become nearly impossible for CHAMO. An outdated AFP has meant non-competitive

physician compensation. This makes it difficult to retain physicians, much less attract new physicians.

- Pediatric specialization adds years of training, and, in at least the case of CHEO, this added specialization is not recognized in compensation - in fact the opposite. A move to adult work (higher paid) or community hospital work (no academic expectations) becomes much more attractive in today's demanding clinical environment. All of this creates a situation in which positions are increasingly being vacated and vacant positions are unable to be filled.

714. Moreover, where new or replacement positions have been filled, these recruitments are typically physicians right out of fellowship with minimal experience or are recruited internationally. Even with this approach, CHAMO struggles to retain physicians for extended period of time resulting in continuing vacancies. There are currently 25 FTE vacancies—approximately 10% of total physician staff—across CHAMO. At this point, CHAMO can no longer offer sufficient remuneration to recruit at any career stage.

715. CHEO has been unable to recruit into the increasing vacancies across all seven of its medical departments, with poor remuneration rates compared to other sites as the most commonly cited reason. The severely outdated CHAMO agreement has led to discrepancies in remuneration with other like pediatric centers in Ontario and an approximating a 40% vacancy rate in positions for some specialties.

716. Several departments have been severely impacted and are struggling to maintain their current complement, let alone recruit replacements. Medical Imaging, for instance, has lost over 42% of its physicians since 2018. Medical Imaging P3/4 MRI and ultrasound wait times are now the longest in the province with a median wait time for P4s of 350 days. While admittedly this wait time has decreased from 750 days, this improvement will not be sustainable due to radiologist and anesthesia shortages. In the past year, 3 radiologists have left CHEO due to non-competitive remuneration and workload. Recruitment to fill retirement vacancies has been increasingly unsuccessful for the same reasons. Medical imaging currently has a 40% vacancy with only 7.4/ 12.6 FTEs in place.

717. The Department of Pediatrics lost 41 physicians (28%) since 2018 compared to only 10 physicians in the five preceding years. Other departments, including the Department of Anesthesiology, are not only losing physicians, but existing doctors are choosing to lower their point codes to supplement with more lucrative opportunities in the community. And the Department of Surgery has lost over 125 years of surgical experience between 2018 and 2021. New recruits were generally recent graduates or internationally trained physicians.

718. In psychiatry, 90% of kids with mental health care needs are waiting up to 18 months for their first appointment. CHEO opened a new Mental Health Transition Unit to deal with high acuity crisis patients, which aims to remove them from the ED environment and provide short stay stabilization and arrange handover to community services ASAP. However, there is urgent need for psychiatrists to staff this unit and address the ongoing surge in mental health inpatient occupancy/acuity.

719. All of this has very real adverse impacts on children. At present, less than 40% of children at CHEO are receiving care within clinically-safe timelines. These unacceptable care delays are, in no small part, due to a physician funding arrangement that is insufficient to meet patient needs.

720. At the same time, total clinic volumes per year for CHEO's medical and surgical ambulatory care clinics illustrate a dramatic increase in demand for care from the community. Surgical wait times were too high before the pandemic, and they continue to climb, with 50% of children waiting longer than is clinically safe for surgery. Crowding in the emergency room was a problem before the pandemic and is now past the breaking point.

721. Retaining clinical staff was difficult before the pandemic and this challenge has now become a crisis with the exodus of clinicians and the inability to attract the new resources needed at current levels of available funding.

722. Inpatient medicine was over 100% occupancy for most weeks over the last year, with inadequate physician positions to staff at baseline levels to care for acute medical inpatients, resulting in poor patient flow, delayed discharges and boarding in the ED with resulting ED bed blockages. Many Pediatric Subspecialty services have to restrict care to P1 and P2 priority

patients, with resultant increased wait times leading to acute presentations in patients who could not access care before their conditions deteriorated.

723. In the immediate term, these pressures are hugely problematic for children, but they will also create long-term impacts that will further increase demand on the healthcare system. At present, CHEO is unable to provide children with sufficiently early intervention and proactive care.

724. The incredible surge in demand for pediatric care, coupled with the worsening physician resource challenges faced by CHAMO and its outdated AFP, has resulted in a pediatric capacity crisis that means babies, children and youth are not receiving expected levels of care. CHEO patients have had unacceptably long wait times, unacceptable cancellations of surgery, and unacceptably crowded and undignified conditions when welcoming patients to the hospital, including the following:

725. The extent to which these significant physician shortages is resulting in unsafe wait times in specialized medical, surgical and mental health care for children and youth in Eastern and North-Eastern Ontario is summarized in “Impact & Evolution of CHEO’s Physician Crisis”[374]. Overall, more than 60% of kids are waiting longer for care at CHEO than is clinically recommended.

726. In sum, current compensation levels have led to an untenable physician resource situation where CHAMO physicians are unable to meet today’s urgent patient needs, let alone address the backlogs of care. This has resulted in moral distress among CHAMO physicians, and an increasing number of stress/medical leaves from pressure on existing physicians.

727. To repair this situation, the OMA proposes to establish a notional rate for each pediatric subspecialty at CHAMO using the 75th percentile of community FFS for full time physicians in each specialty. Pediatric subspecialists practicing at CHAMO require significant, additional training beyond that which would be typically required of their community counterparts. Whereas most CHAMO physicians could transition to practicing in the community, very few community-

[374] CHEO, “Impact & Evolution of CHEO’s Physician Crisis: From recruitment challenge to recruitment and retention emergency” TAB 220 BOD VOL 8.

based specialists possess the necessary skill and expertise to practice at CHEO. Hence, the 75th percentile is an appropriate benchmark to establish notional targets for physicians practicing under the CHAMO AFP.

728. For all of these reasons, and as set out in the OMA proposal contained in the slides reproduced below, it is clear that there is a pressing need for improvements to funding and compensation for CHAMO physicians.

CHAMO AFP RENEGOTIATION

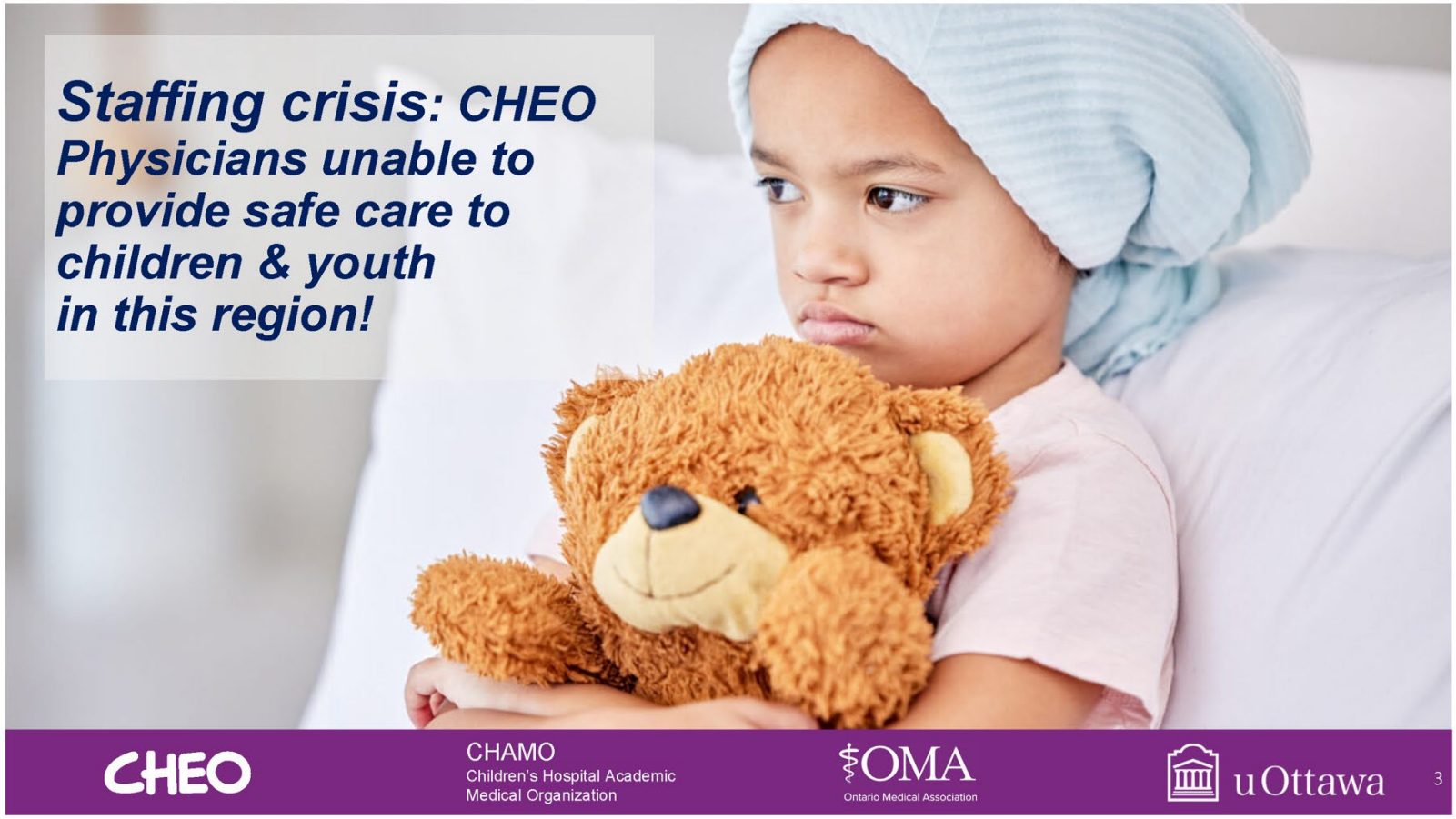
PRESENTED BY: CHAMO RENEGOTIATION TEAM

MARCH 8, 2024

CHEO

Key role in treating acute and chronically ill children & youth in Eastern and North-Eastern Ontario

- Only children's hospital within a **28,000 square kilometer area**
- Serving **600,000 children and youth** annually
- Home to only **1 of 2 pediatric trauma centres** in Ontario
- **Busiest Pediatric ED in Canada**


Staffing crisis: CHEO
Physicians unable to provide safe care to children & youth in this region!
CHEO
CHAMO
Children's Hospital Academic Medical Organization
OMA
Ontario Medical Association
uOttawa
3

How We Got Here

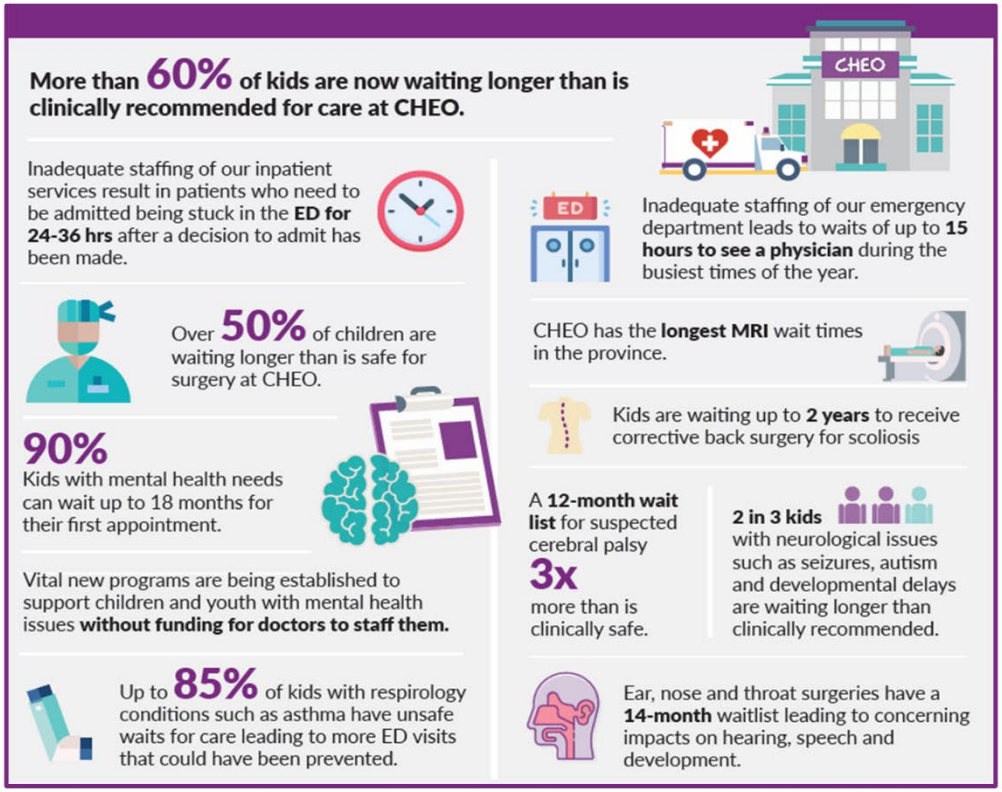
- Children's Hospital Academic Medical Organization (CHAMO) AFP
  - Fully converted AFP that covers 99% of all care provided by CHEO physicians
  - 7 distinct Practice Plans
- CHAMO AFP created in 2002, last renegotiated **18 years ago** in 2006
- **AFP now severely outdated**
- Only modest adjustments as part of subsequent PSAs
- **Large discrepancies in CHAMO remuneration for like work** with academic and community-based counterparts
- Resulting **inability to retain and recruit** physicians, at any career stage, across all clinical departments

CHAMO Physicians are resigning

Table 1. Summary of Net Vacancies: 2012-2023

Practice Plan	New Hires FTEs	Departures* FTEs	New MOH Approved FTEs	Current FTE Vacancies
Anesthesia	8	11.3	1.5	-4.8
Genetics	11.1	5.6	5.5	0
Lab Medicine	8.65	10.15	0	-1.5
Medical Imaging	4	6.2	3	-5.2
Pediatrics	70	48	33	-11
Psychiatry	23	17	6	0
Surgery	14.5	7.5	9.5	-2.5
Grand Total	**139.3**	**105.8**	**58.5**	**-25**

*includes existing vacancies as at 2012



Impact on Safe Care at CHEO

Historic funding investment to *right-size* pediatric health care system

- ***Make Kids Count***
- **Other specialized clinical services (eg, Eating Disorders Expansion)**

Ontario

Newsroom

NEWS RELEASE

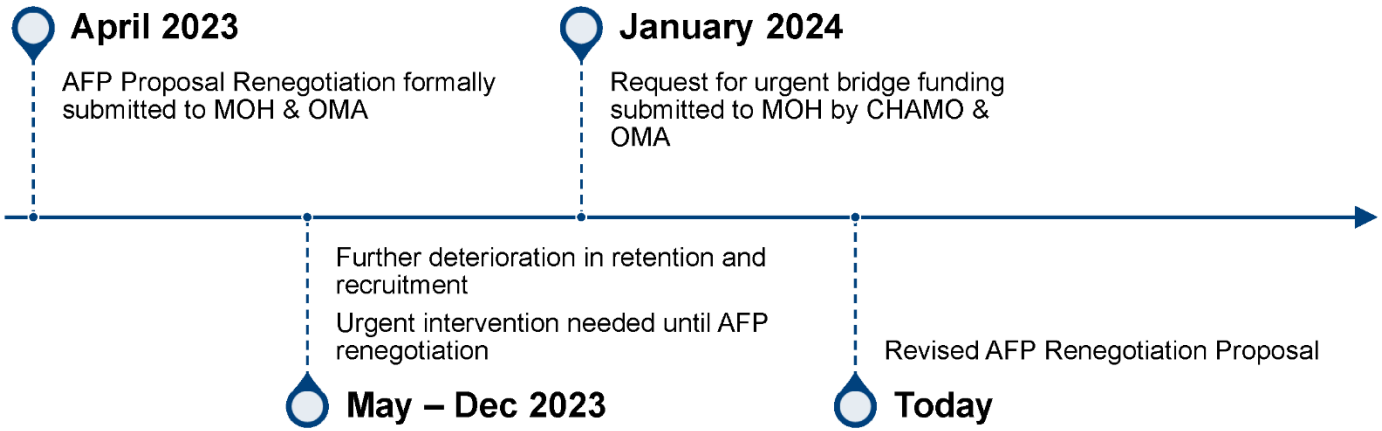
Ontario Connecting Children and Youth to Care Close to Home

$330 million annual boost in spending expands pediatric services in communities across the province

July 19, 2023
Office of the Premier

Funding investment benefits cannot be actualized without corresponding investment in *Physician* resources.

Timelines


April 2023
AFP Proposal Renegotiation formally submitted to MOH & OMA
January 2024
Request for urgent bridge funding submitted to MOH by CHAMO & OMA
Further deterioration in retention and recruitment
Urgent intervention needed until AFP renegotiation
May – Dec 2023
Revised AFP Renegotiation Proposal
Today

Clinical services are decreasing

Peri-Operative Services

- Necessary OR closure days (1000 patients/year) as no anesthetists available, resulting in
  - — major increases in wait times
  - — significant reduction in capacity for less urgent cases
  - — anticipated patient complications
- More anticipated retirements affecting 50% of total anesthesia positions

Psychiatry

- Diversion of Psychiatrist resources from outpatients to cover acute inpatient care services have already impacted
  - — Outpatient psychiatry wait times and specialized/new services (gender diversity, addiction care and Mental Health Transition Unit etc).
  - — Implementation of new operational funding

Pediatrics

- Reduced capacity for inpatient care
  - Unable to fully operationalize funding for level 2/3 ICU
  - Transfer inpatients to other hospitals out of region
  - Increased boarding of admitted patients in ED, impacting ED capacity
  - Reduced outpatient specialty clinics, including post-hospitalization follow ups, to support inpatient care

Clinical services are decreasing

CHAMO AFP PROPOSAL

CHAMO AFP Goal

To renegotiate an AFP that:

1. Enables CHAMO to be competitive in recruiting and retaining highly specialized medical staff
2. Ensures CHAMO does not fall out of parity again in future by including ongoing AFP enhancements

Summary of Proposal

A. Repair CHAMO Physicians to 75%ile	B. Replace Flow Through Methodology	C. Eliminate Conversion	D. Right-size Physician Resources
E. Establish Expansion Fund	F. Fund Clinical Assistants & Clinical PhDs	G. Reduce Shadow Billing Premium	H. Adjust FFS Billing Threshold

A. Repair CHAMO Physicians to 75%ile

Equal pay for equal work:

- Adjust rates/FTE to align with 75th centile of FFS billings by specialty for fulltime community physicians; or
- Align rates with those of provincial specialty APPs, where existing, or at 75th centile, whichever is greater.

A. Repair CHAMO Physicians to 75%ile

Table 2: Repair for Existing and Bridged Positions by Department

Note: This includes the 46.25 positions included in the Bridge, requested at current remuneration rates, thus needing to be repaired.

Department	FTEs				Total Repair
	Existing + Unfunded MDs	New Bridge	Total MD FTEs	Existing PhDs	
Anesthesiology	19		19		6,223,001.79
Genetics	8.5		8.5	5	3,075,833.68
Lab Medicine	6.25		6.25	4	2,106,293.75
Medical Imaging	12.6		12.6		4,885,372.80
Pediatrics	121.25 + 28.25	11	160.5		43,028,467.00
Psychiatry*	23	2	25		3,367,325.00
Surgery	29.5	5	34.5		10,765,813.00
Grand Total	248.35	18	266.35	9	$ 73,452,107.02

The 75th centile is Appropriate Comparator

- CHAMO subspecialists require significant additional (1-3 years) training beyond that required of Community specialists
- Whereas CHAMO specialists and subspecialists can easily migrate to the community, reverse is not true
- 75th centile recognizes crucial roles of CHAMO physicians:
  - — educating future pediatric specialty & primary care medical workforce
  - — developing innovative approaches to providing Ontario children, youth and families with state-of-the-art care

B. Replace Flow Through Methodology

- Eliminate current Flow Through Methodology
- Replace with model that recalibrates target rates by specialty with 75th centile full-time community comparators

C. Eliminate FFS Conversion

- Eliminate FFS Conversion
  - — Original purpose for tracking conversion amounts between FFS and non-FFS pool is no longer relevant
  - — Very onerous and challenging process; interrupted by leaves
  - — Based on FFS system that does not recognize value of pediatric care

- Upon approval of new positions, Ministry will increase the CHAMO AFP by the notional rate for relevant specialty as per proposal A.

D. Right Size Physician Resources

- Request for new positions within each CHAMO Practice Plan to address immediate needs for clinical programs across CHEO

Table 3: Requested Recruitment Positions for Year 1 of AFP by Department

Department	MD FTEs	Recruitment Cost by Department
Anesthesiology	6	3,742,980.00
Genetics	2	914,043.10
Lab Medicine	2.55	1,221,110.85
Medical Imaging	2	1,486,824.00
Pediatrics	32	16,995,790.00
Psychiatry	2	846,520.00
Surgery	9	6,427,654.00
Grand Total	**55.55**	**$ 31,634,921.95**

E. Establish Expansion Fund

- Creation of CHAMO AFP expansion fund equal to 5% of AFP contract value per year
  - Provides stable, secure funding for real time physician recruitments as needed across CHAMO, to respond to urgent surges/crises/HR challenges, moving forward

F. Fund Clinical Assistants and Clinical PhDs

- Amend the CHAMO AFP to fund new CA and Clinical PhD positions
  - Current education models have limited duty hours for all residents
  - No longer acceptable from a safety and quality perspective to rely on residents to provide outpatient and 24/7 in-patient care.
  - Clinical PhDs are integral members of Genetics and Lab Medicine

Table 4: Immediate Year 1 Requests by Department for Clinical Assistants and Clinical PhDs

Department	CAs / PhDs	Recruitment Cost by Department
Anesthesiology		
Genetics	1	278,200.00
Lab Medicine	1	276,000.00
Medical Imaging		
Pediatrics	8	1,600,000.00
Psychiatry		
Surgery		
Grand Total	**10**	**$ 2,154,200.00**

G. Reduce Shadow Billing Premium

- Subject to approval of proposal A (75%ile remuneration rate), the OMA proposes to reduce shadow billing premiums from the current 53.76% to 25%.
  - Will result in estimated 8.2M reduction of CHAMO funding

H. Adjust FFS Billing Thresholds

- Adjust >18 and Reciprocal FFS thresholds by 5% per year
  - — Accounts for AFP growth and changes to Schedule of Benefits
  - — Would include billing for services to adult patients as well as out of scope services

- Current thresholds
  - — >18 yr billings set at $1 M per year
  - — Reciprocal Medical Claims set at $4 M per year

Summary

- CHAMO AFP is severely outdated AND is negatively impacting patient care
  - Remuneration well below community and academic comparators for like work
  - Physician retention and recruitment is a critical issue.
  - *Can no longer provide safe care for children and youth.*

Summary of Proposal

A. Repair CHAMO Physicians to 75%ile	B. Replace Flow Through Methodology	C. Eliminate Conversion	D. Right-size Physician Resources
E. Establish Expansion Fund	F. Fund Clinical Assistants & Clinical PhDs	G. Reduce Shadow Billing Premium	H. Adjust FFS Billing Threshold

Clinical services will be severely impacted

e) Improved AHSC APP Funding

ACADEMIC HEALTH SCIENCE CENTRES AFP

729. Under the 2017-21 PSA, while limited additional funding was provided to the AHSC AFP in innovation funding ($10 million dollars), the key proposal for additional funding for rightsizing and repair was referred to the parties for further discussion. Over five years later, no progress has been made and it is abundantly clear that, without a direction for the necessary funding from this board, no progress will be made. As explained in the outline of the proposal below, it is critical that the 2024-28 PSA include sufficient funding support to enable repair and rightsizing of Ontario's Academic Health Science Centres ("AHSCs").

730. Academic physicians play a special and critical role in the health care system. Academic physicians provide unique clinical services that support the Ontario health care system including specialized tertiary and quaternary services not typically available in community health care settings, such as complex cancer, cardiac, orthopedic, and neurosurgical procedures, transplantation, advanced radiation therapy, ECMO (e.g., for patients with lung failure due to COVID) and the treatment of rare diseases.

731. Complexity of care is high in Academic Medicine. Ontario Hospital Association data show that the Case Mix Index, which measures the allocation of resources required to treat patients, and the number of Tertiary Weighted Cases, which includes patients that require highly specialized skills, technology, and support services are much higher in Academic than Community Medicine. Academic Physicians require competitive remuneration and supports to continue to be attracted to practice in Ontario's teaching hospitals.

732. Academic physicians train the physicians required to care for Ontario's growing and aging population, and drive innovation, which supports Ontario's knowledge-based economy. Academic physicians also drive health care innovation.

733. The proposal set out below, to "Rightsiz[e] Academic Medicine Funding", supported by the province's 17 AHSC Governance Organizations which represent 8,000 Academic Physicians, outlines the evolving landscape of Academic Medicine, describes challenges in the sector that have evolved over the last two decades, and proposes solutions that are designed to maintain a viable, competitive, thriving health care system in Ontario.

734. As the proposal emphasizes, funding for the AHSC AFP has lagged behind growth in Academic Medicine. While the number of Academic Physician Full-Time Equivalents (“FTE”, CIHI definition) in AHSCs increased 34% from 2008 to 2022, the $210,000,000 in base AHSC AFP funding did not change over this time period. This significant dilution of AHSC AFP funds on a per-physician basis has limited the ability to recruit and retain much needed Academic Physicians and has led to challenges providing seamless access to patient care in teaching hospitals. To rightsize AHSC AFP funding by 34% would require $210,000,000 times 34%, or $71,400,000.

735. AHSC AFP funding has also not kept pace with the basic cost of living. The Consumer Price Index (“CPI”) increased by 39.7% from 2008 to 2023, while "flow through" AFP funding (which follows increases in the OHIP Schedule) to Academic Physicians increased 11% over this time period. To account for the difference between the 39.7% increase in CPI and 11% increase in AFP funding from 2008 to 2023 would require an additional $60,252,075.

736. Moreover, educational requirements are increasing. The number of learners (medical students and residents) and Medical Training Days in Ontario increased 31% from 2008 to 2022, and both are projected to increase another 20% from 2024 to 2028 due to the province’s expansion of medical schools. The need for rigorous educational oversight, direct clinical supervision, and competency-based medical education, which have all been mandated by provincial and federal physician regulatory agencies, has increased the time and effort required for Academic Physicians to teach medical learners; these factors will compromise the scalability of medical education in Ontario. This is a crucial limitation, because two thirds of the physicians that practice in Ontario were trained by Academic Physicians at an AHSC in Ontario.

737. Ontario needs more Academic Physicians. At present AHSCs are unable to maintain sufficient physician human resources, and this pressure is growing. Patient care and academic demands, resource constraints, and work / life imbalance have led to the inability of AHSCs to recruit and retain sufficient Academic Physicians, with many transitioning to community practice, moving out of the province, or retiring from the practice of medicine.

738. This proposal advocates a strategic approach to "rightsize" academic physician funding to better align with the increased demands on Academic Physicians and ensure sustainability and effectiveness in addressing Ontario’s health care challenges. This includes updating current

funding models, enhancing support for educational activities, fostering an environment conducive to medical innovation, and continued provision of complex, high quality patient care.

739. To support this investment and ensure accountability, the OMA also proposes that the Academic Medicine Steering Committee be re-established to provide a forum for the Ministry, OMA, Academic Physicians, AHSCs and Universities to engage in long-term human resource planning, enable development of new models of care, and explore non-fee-for-service Academic Physician funding arrangements.

RIGHTSIZING ACADEMIC MEDICINE FUNDING

BARRY RUBIN MD PHD DFSVS FACS FRCSC
PROVINCIAL LEAD
ACADEMIC HEALTH SCIENCE CENTRE

GOVERNANCE ORGANIZATIONS

JANUARY 2024

AGENDA - RIGHTSIZING ACADEMIC MEDICINE FUNDING

1. Original intent of the Provincial AFP.
2. Changes in Academic Medicine from 2008 to 2022.
   a. Number of physicians and FTEs in Academic Medicine.
   b. Provincial AFP funding.
   c. Complexity of care, Academic vs Community practice.
   d. Number of learners (medical students, residents) and Medical Training Days at Academic Health Science Centres – current and projected growth.
   e. Impact of Innovation provided by Academic Physicians on healthcare in Ontario.
   f. Health care services only provided by Academic Physicians.
3. Request to rightsize AFP funding across Academic Medicine, and re-establish the Academic Medicine Steering Committee.

REPORT OF THE PROVINCIAL WORKING GROUP: AFP FOR ACADEMIC HEALTH SCIENCE CENTRES*

1. Ontario AHSCs compete in an international market for highly skilled and educated academic physicians.
2. AHSCs are facing recruitment and retention challenges for increasingly scarce academic physicians.
3. Large community hospitals are increasingly viewed by academic physicians as attractive alternatives to the traditional AHSC.
4. For these and other reasons, representatives of the Ministry of Health and Long-Term Care and the OMA agreed in the course of their negotiations in spring 2000, the implementation of AFPs for the four AHSCs in Hamilton, London, Ottawa and Toronto (2000 OMA/MOHTLC Agreement).

*Government of Ontario, Report to the Minister of Health, 2002

ACADEMIC MEDICINE – REALITIES

1. Two thirds of the MDs in Ontario were trained at a teaching hospital in Ontario, including Primary Care MDs. To have enough MDs to manage Ontario's growing and aging population and not depend on the relocation of physicians from other jurisdictions, Ontario needs strong teaching hospitals.
2. The most complex health care in Ontario is provided at teaching hospitals.
3. Health care innovation, a driver of Ontario's knowledge-based economy is almost exclusively carried out by academic physicians.
4. Academic physicians spend significant time fulfilling teaching, research and innovation mandates, which are all less well remunerated than the provision of clinical services.

ACADEMIC MEDICINE – CHALLENGES

5. Recruitment and retention of academic physicians has become increasingly difficult.
   a. Academic physicians are moving to community practice.
   b. Academic physicians have been recruited to other provinces or countries.
   c. Some teaching hospitals are unable to provide seamless on-call coverage for some services (e.g., General Internal Medicine at UHN).
6. There are high levels of burnout among academic physicians due to patient care and academic demands, resource constraints, and work / life imbalance.*

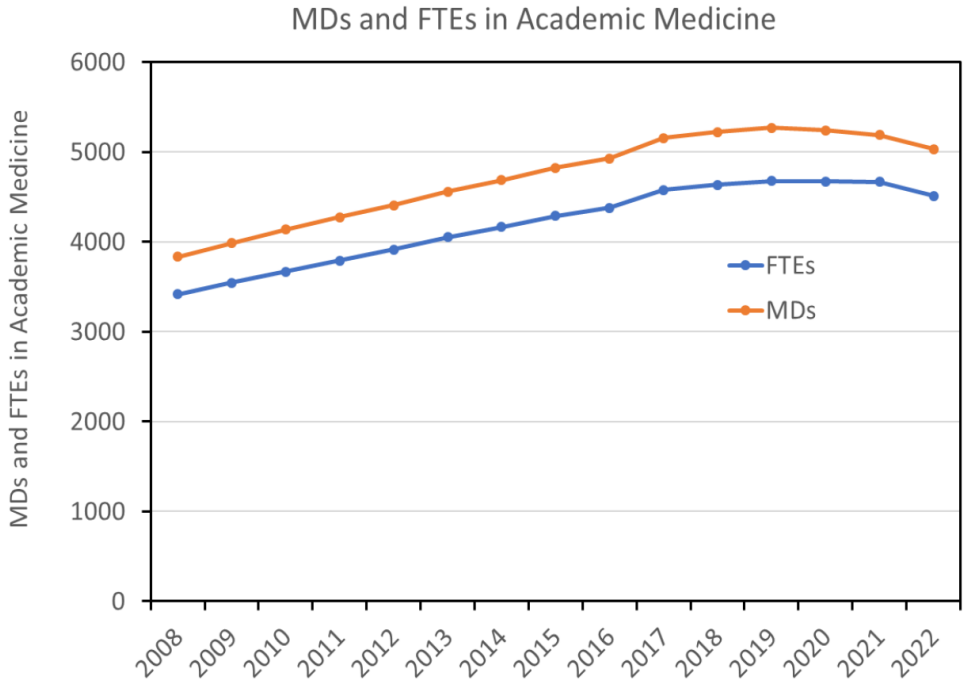
*Rubin et al. CMAJ Open 11;9(1):E10-E18, 2021.

THE NUMBER OF FTES INCREASED 34% ACROSS ACADEMIC MEDICINE FROM 2008 - 2023

Includes physicians who billed with a group number associated with one of the AHSC governance sites.*

Does not include academic MDs at AHSCs in Family Health Teams (497) or fully converted AFPs (1,290).

Data from the OMA.



4% **decrease** in Academic MDs and Academic FTEs from 2019 to 2022.

*Baycrest, Ottawa Hospital, Women's College, U of Ottawa Heart Institute, Hamilton, Mount Sinai, London, Montfort, Sunnybrook, St. Michael's, Royal Ottawa, CAMH, UHN.

AFP FUNDING RECEIVED BY ACADEMIC PHYSICIANS INCREASED 11% FROM 2008 – 2023

	AFP Funding to	2008 PSA			2012 PSA +UA	2017 PSA	2021 PSA
	Academic MDs	01-Oct-09	01-Oct-10	01-Sep-11	01-Apr-12	01-Apr-17	01-Apr-23
Percent change		5.20%	2.50%	3.57%	-3.58%	3.54%	2.01%
Phase I	$75,000,000	$78,900,000	$80,872,500	$83,759,648	$80,759,551	$83,618,439	$85,299,170
Clinical Repair	$65,000,000	$68,380,000	$70,089,500	$72,591,695	$69,991,611	$72,469,314	$73,925,947
Teaching and Research	$60,000,000	$60,000,000	$60,000,000	$60,000,000	$60,000,000	$62,124,000	$63,372,692
Recruitment	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,354,000	$10,562,115
Total	**$210,000,000**	**$217,280,000**	**$220,962,000**	**$226,351,343**	**$220,751,162**	**$228,565,753**	**$233,159,925**

Does not include payment discounts (that were subsequently reversed), any one-time adjustments, or new AHSC AFP arrangements negotiated that were not part of the original $210,000,000 allocation (Montfort, NOSM).

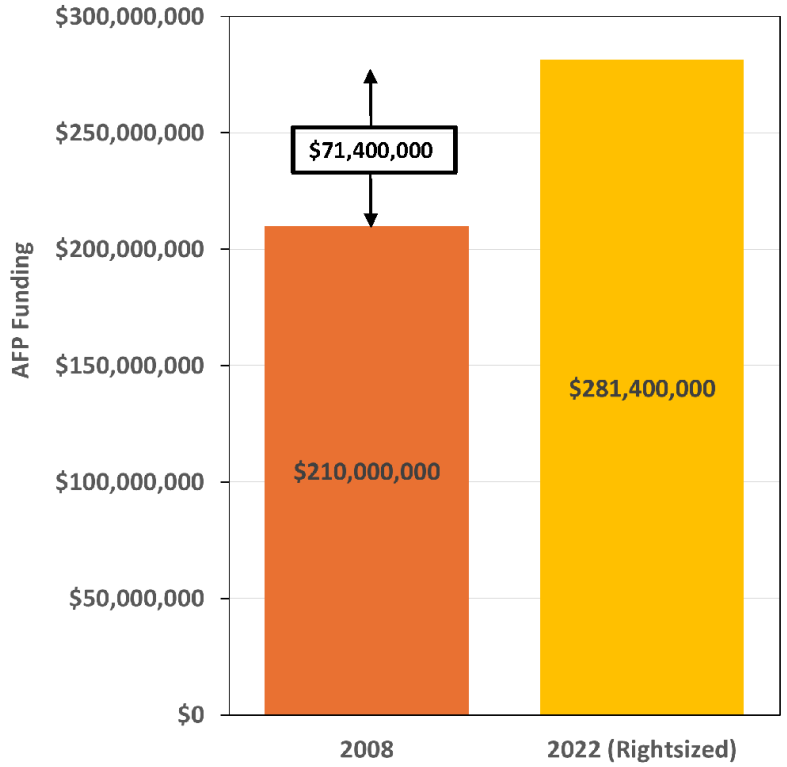
AFP Funds not received by academic physicians also include:

a. Innovation: 2008 - $10,000,000; 2023 - $20,402,000.
b. Administration: 2008 - $5,000,000; 2023 - $5,281,058.

FUNDS REQUIRED TO RIGHTSIZE AFP FUNDING TO 2008 LEVELS

1. The number of FTEs in Academic Medicine increased **34%** from 2008 to 2022.
2. No additional AFP funding has been provided to account for the growth in FTEs in Academic Medicine from 2008 to 2022.
3. To rightsize AFP funding by 34% would require $210,000,000 × 0.34 = **$71,400,000**.

FUNDS REQUIRED TO RIGHTSIZE AFP FUNDING TO 2008 LEVELS



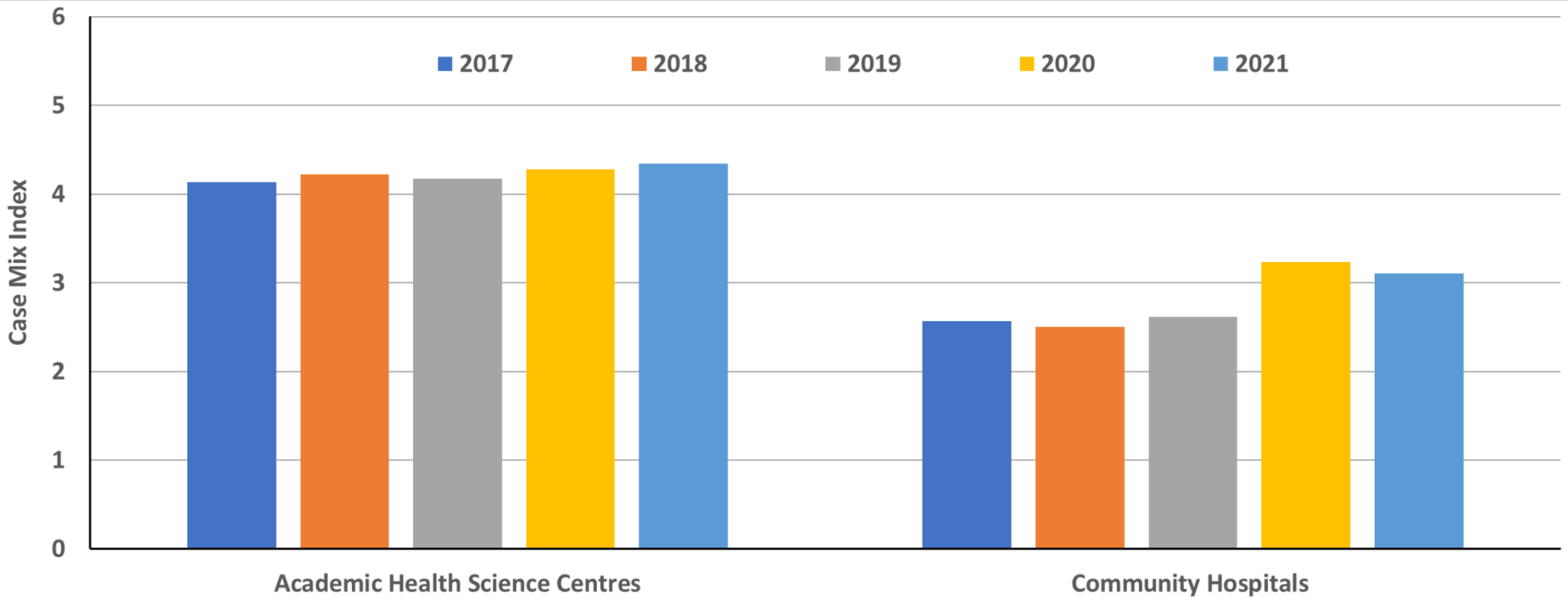
FUNDS REQUIRED TO RIGHTSIZE AFP FUNDING TO 2008 LEVELS AND ACCOUNT FOR INFLATION

1. The consumer price index (CPI) increased by 39.72% from 2008 to 2023.*
2. To account for the 39.72% increase in CPI would require $210,000,000 × 0.3972 = $83,412,000.
3. AFP "flow through" funding to academic physicians from 2008 to 2022 was $233,159,925 - $210,000,000 = $23,159,925.
4. Therefore, $83,412,000 - $23,159,925 = **$60,252,075** is required to account for the 39.72% increase in CPI from 2008 to 2023.

* https://www.bankofcanada.ca/rates/related/inflation-calculator

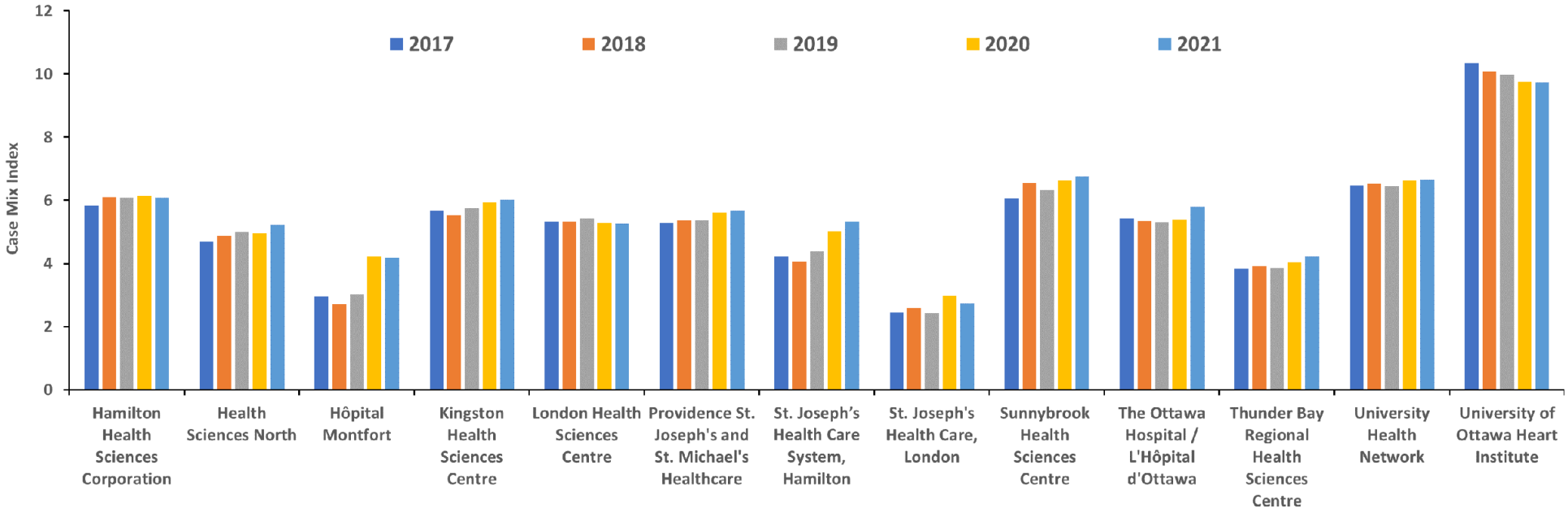
FUNDS REQUIRED TO RIGHTSIZE AFP FUNDING TO 2008 LEVELS AND ACCOUNT FOR INFLATION

COMPLEXITY OF CARE CONTINUES TO BE HIGHER IN ACADEMIC VS COMMUNITY PRACTICE: CASE MIX INDEX



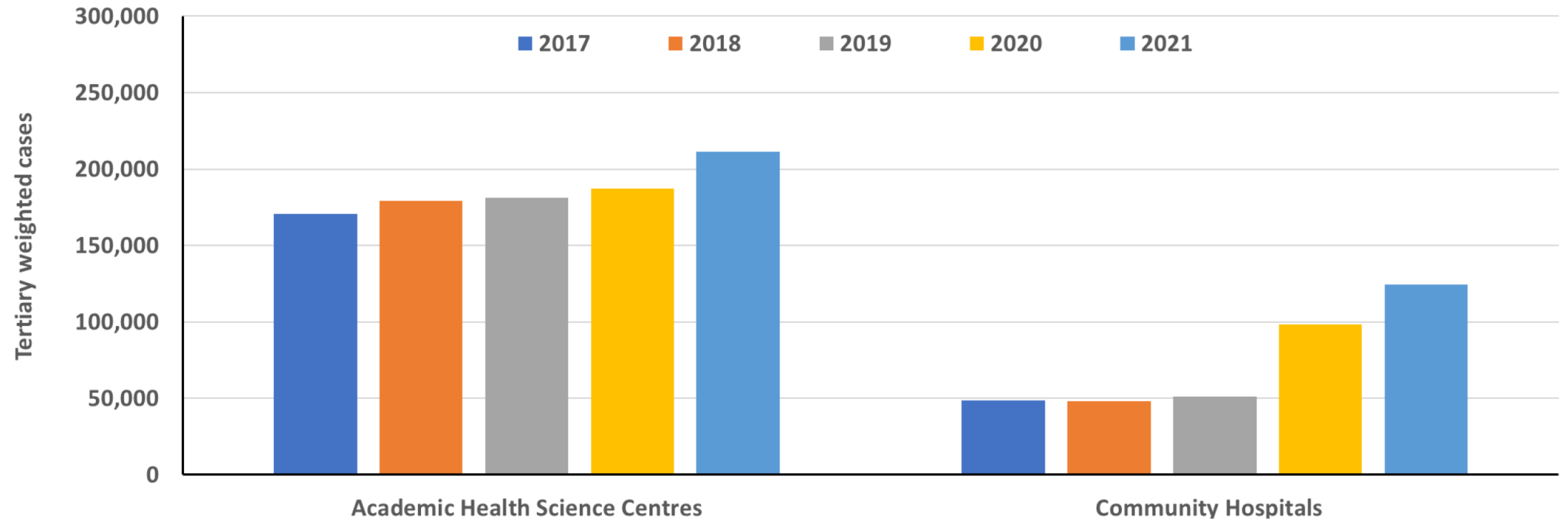
* Case mix index (CMI) measures the allocation of resources required to care for and/or treat patients in a group. Data from the OHA.

COMPLEXITY OF CARE CONTINUES TO BE HIGHER IN ACADEMIC VS COMMUNITY PRACTICE: CASE MIX INDEX



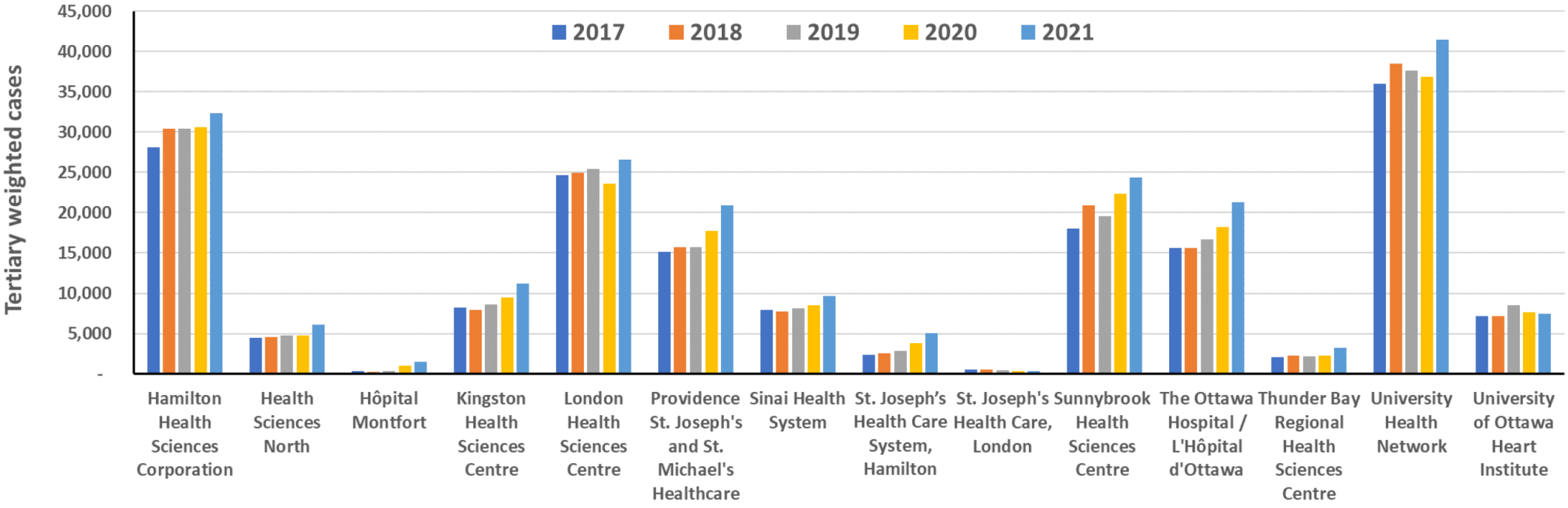
* Case mix index (CMI) measures the allocation of resources required to care for and/or treat patients in a group. Data from the OHA.

COMPLEXITY OF CARE CONTINUES TO BE HIGHER IN ACADEMIC VS COMMUNITY PRACTICE: TERTIARY WEIGHTED CASES



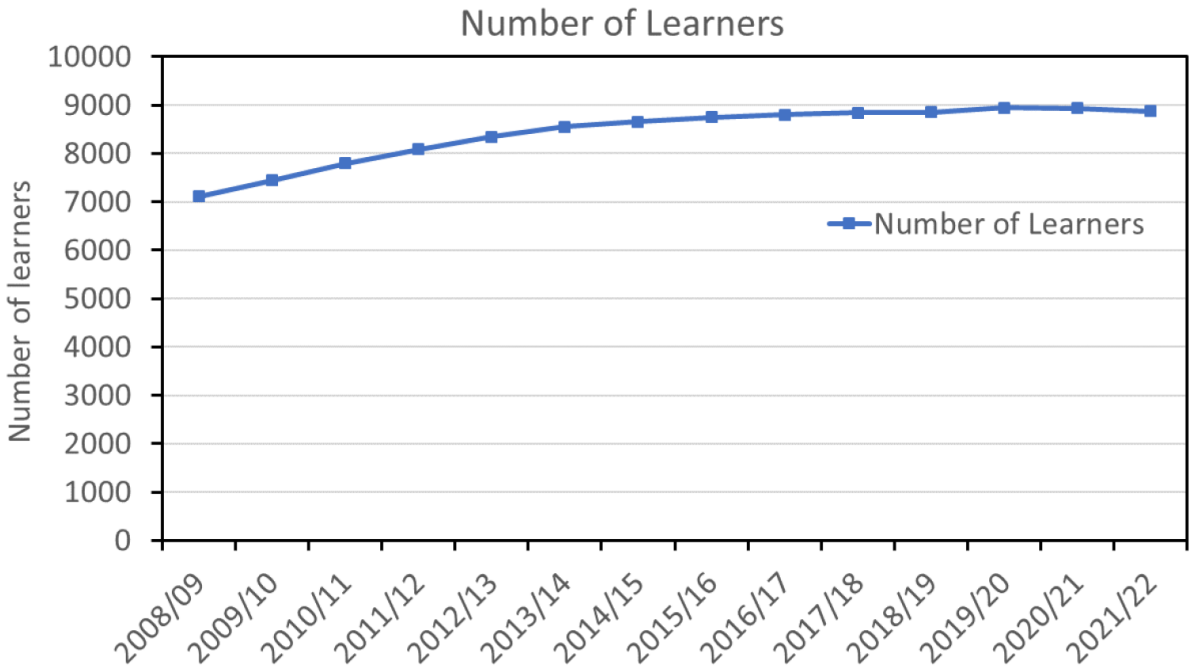
* Tertiary weighted cases represent patients that require highly specialized skills, technology, and support services. Data from the OHA.

COMPLEXITY OF CARE CONTINUES TO BE HIGHER IN ACADEMIC VS COMMUNITY PRACTICE: TERTIARY WEIGHTED CASES



* Tertiary weighted cases represent patients that require highly specialized skills, technology, and support services. Data from the OHA.

THE NUMBER OF LEARNERS AT ACADEMIC HEALTH SCIENCE CENTRES INCREASED 31% FROM 2008 TO 2023*



* Learners include medical students and residents. Data from OMA Economics.

MEDICAL TRAINING DAYS AT ACADEMIC HEALTH SCIENCE CENTRES INCREASED 31% FROM 2008 TO 2022

Facility Details				2007-08				2022-23				CHANGE	
Affiliation	Medical School[2]	CODE	NAME	Clerk	Resident	Fellow	TOTAL[1]	Clerk	Resident	Fellow	TOTAL[1]	Absolute[3]	Proportional[4]
Teaching	McMaster	674	ST JOSEPH'S HEALTH CARE SYSTEM-HAMILTON	13821	49266	4299	**67386**	14610	62248	18304	**95162**	**86802**	**41%**
		942	HAMILTON HEALTH SCIENCES CORPORATION	33327	113111	18845	**165283**	25845	132189	46091	**204124**	**38841**	**23%**
	NOSM	935	THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE	696	9539	0	**10235**	6742	14662	652	**22056**	**11821**	**115%**
		959	HEALTH SCIENCES NORTH	728	7632	0	**8360**	8212	14513	168	**22893**	**14533**	**174%**
	Ottawa	651	ROYAL OTTAWA HEALTH CARE GROUP	664	3934	1275	**5873**	2325	6099	194	**8619**	**2746**	**47%**
		751	CHILDRENS HOSPITAL OF EASTERN ONTARIO	9059	26634	7706	**43399**	9722	36389	7659	**53770**	**10371**	**24%**
		753	HOPITAL MONTFORT	5677	4940	60	**10677**	11563	10658	8	**22229**	**11552**	**108%**
		932	BRUYERE CONTINUING CARE INC.	761	5430	308	**6499**	594	8579	137	**9310**	**2811**	**43%**
		958	OTTAWA HOSPITAL (THE)	19800	161025	32635	**213460**	32653	169315	38467	**240435**	**26975**	**13%**
	Queen's	692	HOTEL DIEU HOSPITAL	2033	8237	60	**10330**	0	12	0	**12**	**-10318**	**-100%**
		693	KINGSTON GENERAL HOSPITAL	18249	58575	3843	**80667**	25576	85792	10401	**121768**	**41101**	**51%**
		695	PROVIDENCE CARE CENTRE	1491	2606	451	**4548**	632	5731	952	**7315**	**2767**	**61%**
	Toronto	632	NORTH YORK GENERAL HOSPITAL	4819	14298	237	**19354**	5682	18880	758	**25320**	**5966**	**31%**
		827	BAYCREST CENTRE FOR GERIATRIC CARE	63	3120	1106	**4289**	146	2426	1176	**3747**	**-542**	**-13%**
		837	HOSPITAL FOR SICK CHILDREN (THE)	8773	49474	64466	**122713**	5760	61061	88803	**155623**	**32910**	**27%**
		852	ST MICHAEL'S HOSPITAL (Unity Health in 2022)	19993	56069	12970	**89032**	28484	99149	50280	**177914**	**88882**	**100%**
		862	WOMEN'S COLLEGE HOSPITAL	2313	6426	2527	**11266**	2724	19142	6510	**28376**	**17110**	**152%**
		939	HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL	48	313	705	**1066**	130	1660	738	**2527**	**1461**	**137%**
		947	UNIVERSITY HEALTH NETWORK	26123	121487	95590	**243200**	20524	124776	172036	**317336**	**74136**	**30%**
		948	CENTRE FOR ADDICTION AND MENTAL HEALTH	2333	10778	3469	**16580**	4495	22603	5168	**32265**	**15685**	**95%**
		953	SUNNYBROOK HEALTH SCIENCES CENTRE	18585	82084	39591	**140260**	17569	85916	54317	**157801**	**17541**	**13%**
		976	SINAI HEALTH SYSTEM	16284	74504	28730	**119518**	13788	63555	39938	**117281**	**-2237**	**-2%**
	Western	714	ST.JOSEPH'S HEALTH CARE LONDON	7542	29529	6759	**43830**	6534	30487	8215	**45235**	**1405**	**3%**
		936	LONDON HEALTH SCIENCES CENTRE	31459	133238	25269	**189966**	45788	154532	56415	**256734**	**66768**	**35%**
ACADEMIC TOTAL MTDs[1]				**244641**	**1032249**	**350901**	**1627791**	**290095**	**1230374**	**607386**	**2127855**	**500064**	**31%**

THE EFFORT REQUIRED TO TEACH AND EVALUATE LEARNERS HAS INCREASED FROM 2008 TO 2023

The Royal College of Physicians and Surgeons of Canada **Competence by Design** and Ontario College of Family Physicians outcomes-based approach to learning mandates that all faculty must:

1. Design and evaluate Entrustable Professional Activities (EPAs)*, assessed in aggregate by competency committees.
2. Observe clinical exams.
3. Directly observe supervision.

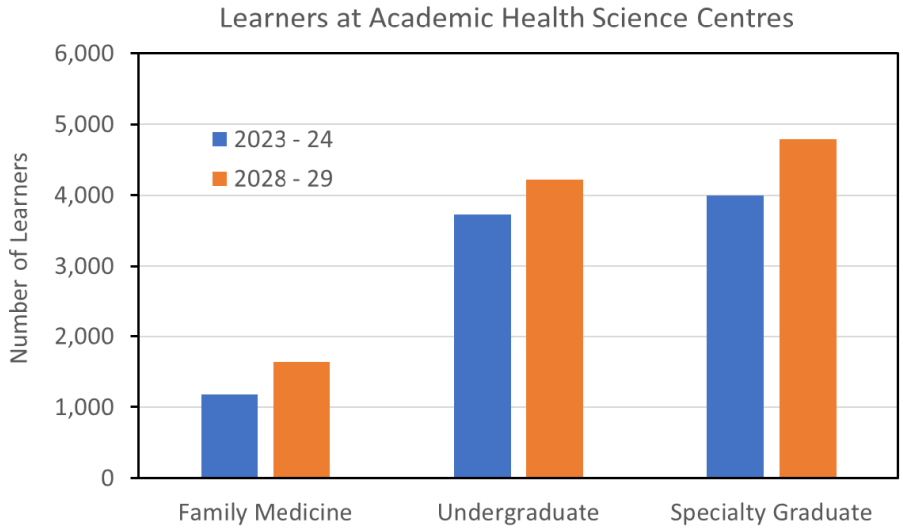
The emphasis on experiential learning means most of medical education is not scalable (i.e., can't just put more students in a classroom).

Greater degree of rigor and process in curriculum design, curriculum delivery, expected learner supports, comprehensive documentation, and accreditation standards.

* A stage-specific clinical task that an individual can be trusted to perform in a given health care context, once they have demonstrated sufficient competence.

MEDICAL SCHOOL EXPANSION: THE NUMBER OF LEARNERS AT AHSCs IS PROJECTED TO INCREASE 20% BY 2028

Medical School	Undergraduate Expansion (phased in, 2022 - 2026)	Postgraduate Expansion (phased in, 2024 - 2028)
McMaster	14	50
NOSM U	44	63
Ottawa	14	50
Queen's	34	52
Toronto	44	67
Western	16	50
Total	**166**	**332**



Additional academic physicians will be required to teach these new learners.

* https://news.ontario.ca/en/release/1001773/ontario-training-more-doctors-as-it-builds-a-more-resilient-health-care-system

MEDICAL SCHOOL EXPANSION: THE NUMBER OF LEARNERS AT AHSCs IS PROJECTED TO INCREASE 20% BY 2028

Doug Ford, Premier: "As our province grows, our government has a plan to build a stronger, more resilient health care system. Too many Ontario students are having to go abroad for medical school because they can't find residency spots here in their home province while international students learn here then leave. That's why we're expanding the number of undergraduate and graduate medical school spots and putting qualified Ontario students at the front of the line. We're training the next generation of Ontario doctors right here in Ontario to stay here and care for Ontario communities."

The new investment in Budget 2023 to add another 100 undergraduate medical school seats and another 154 postgraduate medical training seats builds on the expansion of 160 undergraduate and 295 postgraduate medical training seats announced last year, the largest expansion of Ontario's medical school system in over a decade.

Sylvia Jones, Deputy Premier and Minister of Health: "Increasing the number of doctors and other health care workers will make it easier for Ontarians to connect to world class health care right in their own communities. We will continue to implement our bold plan to grow our health workforce so Ontarians can continue to receive care closer to home for years to come."

* https://news.ontario.ca/en/release/1001773/ontario-training-more-doctors-as-it-builds-a-more-resilient-health-care-system
** https://news.ontario.ca/en/release/1002882/province-helping-more-ontario-students-become-doctors-at-home-in-ontario

ACADEMIC HEALTH SCIENCE CENTRES
DRIVE INNOVATION

AHSCs drive innovation and contribute to Ontario's knowledge-based economy.

1. $10 million / year AHSC Innovation Fund created in 2008 by the Ministry of Health and OMA, increased to $20 million / year in 2017.
2. Over $200 million has been allocated to support 2,300 projects through the AHSC Innovation Fund since 2008 – 09, with oversight from the Innovation Fund Provincial Oversight Committee (IFPOC).
3. Many projects supported by the Innovation Fund have led to additional funding from peer-review agencies (CIHR) and international awards, and many have been implemented across Ontario.

IMPACT OF THE AHSC INNOVATION FUND:
SELECTED HIGH-PROFILE PROJECTS

1. Development, calibration & testing of a Pediatric Automated Mobile Play Audiometer. Matt Bromwich, **CHEO**.
2. Evaluation of a Unique Canadian Community Outreach Program Providing Obstetrical Care for Pregnant Adolescents. Nathalie Fleming and Amanda Black, **The Ottawa Hospital**.
3. Bridge or continue coumadin for device surgery - RCT. David Birnie, **The Ottawa Heart Institute** (NEJM).
4. Post op home monitoring after joint replacement. Homer Yang, **The Ottawa Hospital** (now in London).
5. Harnessing mobile health technology to personalize the care of CKD patients. Sandy Logan, **Sinai / UHN**.
6. Functional Recovery in Critically Ill Children: the "Weecover" longitudinal cohort study. Karen Choong and Douglas Fraser, **Hamilton Health Sciences Centre** and **London Health Sciences Centre.**
7. Improving Decision-making for Empiric Antibiotic Selection (IDEAS). Nick Daneman, **Sunnybrook**.

CLINICAL SERVICES THAT ARE ONLY PROVIDED BY ACADEMIC PHYSICIANS

1. Mechanical support for lung failure due to COVID or influenza (ECMO).
2. Liver, heart, lung, kidney, pancreas, small bowel, corneal, stem cell and hand transplantation.
3. Management of complex heart and blood vessel diseases.
4. Complex medical and surgical cancer therapy, with simultaneous reconstructive surgery.
5. Deep brain stimulation for Parkinson's Disease, movement disorders and dementia.
6. Complex obstetric and gynecologic procedures.
7. Management of patients with rare diseases.

SUMMARY – ACADEMIC MEDICINE IN ONTARIO

1. The number of FTEs in Academic Medicine increased 37% from 2008 to 2020, and then fell 4% between 2020 and 2022 (i.e., during the COVID the pandemic).

2. AFP funding to academic physicians increased 11% from 2008 to 2022.

3. Patient complexity at AHSCs has increased progressively over the last 5 years and is significantly higher in Academic than in Community practice.

SUMMARY – ACADEMIC MEDICINE IN ONTARIO

4. Academic physicians provide unique clinical services that support the Ontario healthcare system.

5. Academic physicians drive innovation and support Ontario's knowledge-based economy.

6. The time commitment required to meet College of Family Physicians of Canada, Royal College, and the Committee on Accreditation of Canadian Medical Schools teaching evaluation standards has increased significantly over the last 15 years, and the number of learners academic physicians will be required to teach will increase 20% by 2028.

ARBITRATION DECISION: 2017 PHYSICIAN SERVICE AGREEMENT

Academic Health Sciences Centre and NOSM Proposals

- The parties are directed to continue discussions regarding the other aspects of the OMA's NOSM and AHSC proposals, in particular for **rightsizing and repair**.
- Where consensus cannot be reached on AHSC or NOSM issues, either party may trigger further mediation with the assistance of the board or the Chair.

REQUEST TO RIGHTSIZE FUNDING AND ADDRESS CHALLENGES IN ACADEMIC MEDICINE IN ONTARIO

1. Rightsize AFP funding.
   a. **$71,400,000** to rightsize AFP funding to 2008 levels.
   b. **$60,252,075** to account for the 39.72% increase in the CPI since 2008.
   c. Total required is $71,400,000 + $60,252,075 = **$131,652,075**.

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2. Re-establish the Academic Medicine Steering Committee, with co-leads from the Ministry and OMA to address complex, ongoing issues: long-term human resource planning, enabling new models of care, and interest in non fee-for-service academic physician funding arrangements.

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3. Carry out a mid-term reassessment in 2026 to account for further increases in academic physicians and teaching requirements.

f) Physicians Practicing under Divested Provincial Psychiatric Hospitals ("DPPHS")

740. There are 9 Divested Provincial Psychiatric Hospitals ("DPPHs") in Ontario. While various types of practice arrangements exist within the DPPHs, the majority of psychiatrists work under the employment model, are paid an annual salary, and generally also receive the same benefits as other employees within their organizations.

741. As part of the 2008 PSA, the OMA and the ministry implemented a top-up program to allow physicians working in DPPHs to receive a minimum compensation level based on the physicians' type and level of work. As part of this work, the parties agreed to establish a minimum target rate and top-up physicians to that target rate. This resulted in a two-stream funding mechanism where the majority of physician compensation would flow from hospital global budgets while OHIP would top-up physicians to a target rate. The target rate has been adjusted in line with psychiatry increases resulting from each subsequent PSA.

742. The current funding structure has created a number of challenges including:

(a) Significant delays in the flow of funds - Top up funding is determined based on reporting from each hospital which can occur at the end of each fiscal year, resulting in significant delays in the flow of funds. For example, although most physicians in the province received permanent year 2 increases on April 1, 2023 as per the financial agreement outlined in 2021 PSA, physicians practicing under DPPH models have yet to receive these adjustments.

(b) Adjustments up to target rate – Adjusting funds only up to a target rate means many physicians are not eligible for top-up funding, including many part time physicians whose pro-rated funding and FTE values make them ineligible for top ups. This has created an artificial cap on physician earnings under the DPPH that can result in physicians reducing their clinical activities at DPPHs once FTE requirements are met.

(c) Reporting Disputes – Despite multiple attempts to standardize compensation reporting from hospitals, significant disparities in the reporting of compensation components continue to persist. This often results in hospitals needing to resubmit reports, creating additional delays in top up payments to physicians.

743. The OMA proposes the following changes to the approach to flowing through compensation increases to these physicians:

(a) Structure DPPH adjustments as follows:

(i) Target rate to be adjusted by the psychiatry specialty increase;

(ii) DPPH physicians receiving total compensation below the new target rate will have their total compensation topped up to the new target rate; and

(iii) DPPH physicians who are receiving total compensation that is above the new target rate will receive the psychiatry increase applied on their current total compensation.

G. TARGETED FUNDING FOR TECHNICAL FEES

I. Background and Rationale for OMA Technical Fee Proposal

744. In 2018, the Kaplan board of arbitration directed as follows:

> *The parties are also directed to continue discussions regarding the OMA's additional technical fees proposals.*
>
> *Where consensus cannot be reached on technical fees issues, either party may trigger further mediation with the assistance of the board or the Chair.*
>
> *It is our hope that discussion, mediation and fact finding during this mediation process will set the stage for efficient and productive future processes.*

Unfortunately, while the OMA did some internal work in respect of its proposals, there was no substantive bilateral negotiations or discussion.

745. Subsequently, under the 2021-24 PSA, the parties agreed as follows, explicitly mutually recognizing this "as a matter of priority":

> *- The parties will jointly participate in the work of the technical fees working group, informed by work the Ontario Medical Association has already begun;*
>
> *- The Ministry retains the right to propose additions but not deletions to the existing Terms of Reference, attached as Appendix 1;*
>
> *- For the purposes of the work of this Technical Fees Committee, William Kaplan, as the sole mediator/arbitrator, shall be seized with respect to resolving any issues arising out of the parties' efforts to agree on the terms of reference, to conclude and carry out the terms of reference governing this work, and to resolve any methodological differences concerning factors relevant to determining funding to support the technical component of providing medical services;*
>
> *- The parties agree that this agreement to refer issues in dispute above to arbitration is without prejudice to either party's position otherwise on the arbitrability of these kinds of issues under the BAF.*
>
> *- The parties' intention is that the Working Group complete its work by March 31, 2024.*

746. The terms of reference for the work of the Technical Fee Working Group, as set out in Appendix 1, are as follows:

Appendix 1 – Technical Fee Working Group Terms of Reference Engaging with the Ministry of Health on the following areas, as appropriate

Continue discussions regarding the OMA's technical fee proposals, asper the 2017 Kaplan Arbitration Award

Planning and Strategies to Address Health Care Needs

Using a planning-based approach to the diagnostic services system, recommend strategies to address access and health care needs with a patient focus – including access in under-serviced areas, new approaches to meet patient needs, addressing capacity and wait lists, improving patient education, educating physicians on referral patterns and guidelines etc.

Funding and Structure

To provide advice and recommendations on the funding and structure for the province-wide diagnostic system based on growth, supply, and changing patient needs. To provide advice and recommendations for the use of any new funding, and for the funding of new diagnostic services.

Quality and Service Standards

To provide advice to strengthen quality assurance practices and guidelines. Using a collaborative approach, develop strategies to move toward a systemic and integrated approach to quality management to support appropriate quality and service standards for diagnostic services.

Compensation of Technical Component

To develop and establish how the technical component of diagnostic services (currently described as technical fees) will be evaluated, compensated, and administered, including establishing a fair costing methodology, and an ongoing review process to reflect that reimbursement is based on fair costing and current service volumes.

Utilization Management

To develop and recommend a province-wide utilization management process for the system, including technical fees. To conduct periodic reviews of utilization and utilization trends and provide advice on appropriate evidence-based utilization management.

New Diagnostic Technologies

To consider and develop a framework for the implementation, distribution, quality management, and funding to support new diagnostic technologies.

Capital and Equipment

To assess and make recommendations concerning equipment acquisition and replacement issues and related equipment standards and quality assurance.

747. Unfortunately, while the OMA was extremely committed to completing the work of the task force prior to the expiry of the 2021-24 PSA, very little bilateral progress has been made. It is abundantly clear that without direction from this board of arbitration to increase technical fees, no meaningful progress will be made.

II. Background to OMA Technical Fee Proposal

748. To give this Board some context and background concerning the need for increases to technical fees, immediately below we reproduce the submissions made by the OMA with respect to technical fees in its 2017-21 PSA arbitration brief. Indeed, what the OMA said then is even more true today, as reimbursement for technical fees has fallen even further behind over the ensuring years. Below are the excerpts from the earlier arbitration brief:

The Issue

1. Diagnostic services, other than those provided to hospital inpatients, typically have separate professional and technical fee components. The professional fees listed in the OHIP Schedule are intended to remunerate physicians for providing the service and interpreting its results.

2. The technical fees listed in the OHIP Schedule and the Schedule of Facility Fees for Independent Health Facilities are intended to defray the costs associated with the provision of insured diagnostic services. The constituent components of technical fees are:

- *Preparing the patient for the procedure; Performing the diagnostic procedure(s);*
- *Making arrangements for any appropriate follow-up care;*
- *Providing records of the results of the procedure to the interpreting physician;*
- *Discussion with, and providing information and advice to, the patient or*

patient's representative, whether by telephone or otherwise, on matters related to the service;

- *Preparing, and transmitting, a written, signed and dated interpretive report of the procedure to the referring physician;*

- *Providing premises, equipment, supplies and personnel for all specific elements of the technical and professional components except for the premises for any aspects of the professional component associated with clinical supervision and interpreting the results of the diagnostic procedure.*

3. While these costs have varied over time due to numerous factors (including inflation and changes in technology), there has been no mechanism in place to provide a systemic understanding of these expenses and the changes to them.

4. As described below using various models and studies, the gap between the technical fee and the cost of providing the diagnostic service has grown between 38% and more than 200% over the past 20 years depending on the particular service. This growing gap has been largely ignored and has, in many cases, left physicians subsidizing the cost of providing the service with their professional fees which is neither acceptable nor sustainable. There must be a process/mechanism to ensure that technical fees reflect the true cost of providing the service.

5. In the OMA's view, it has become imperative to develop a process to properly measure and reimburse the technical cost[375] of diagnostic services which includes a mechanism for the continuous introduction, evaluation and renewal of diagnostic services and of the technical component of those services in all settings (public hospitals, Independent Health Facilities and Out of Hospital Premises).

A. Prior Bilateral Findings up to 2008

The Diagnostic Services Committee (DSC) was established under the 2004 Physician Services Agreement as a tripartite advisory body to the Ontario Ministry of Health and Long Term Care (MOHLTC), comprising the OMA, the Ontario Hospital Association and the MOHLTC. In March 2008, it released the Progress and Priorities Report which identified a need for additional funding for diagnostic

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[375] *This initiative is not intended to address simple items such as "tray fees" for minor office-based procedures or for laboratory services provided in physician's offices. Rather, it is intended to address services that generally require a significant capital investment in the equipment required to provide the service or significant operational expenses.*

services, noting that "Current funding for diagnostic services does not reflect today's cost and service delivery realities."[376]

6. The trilateral work of the DSC and its subcommittees in 2007 and 2008 highlighted the enormous gap in funding that existed even then. As part of the DSC's work, the Task Force on Technical Compensation (TFTC) was established to make recommendations on how the technical component of diagnostic services should be evaluated, compensated and administered. The TFTC's March 19, 2008 report[377] *to the DSC included a detailed evaluation of the technical fee component for five diagnostic services; X091, X113, X185, X224 and J135 (see Table 1 below).*

7. Results of the evaluation indicated that the 2008 fee values (which were greater than the 2017 fee values!) should be increased by ***between 32.5% and 289.7%*** *to appropriately account for the true costs of rendering the diagnostic service depending upon service location and equipment modality.*

[376] *Diagnostic Services Committee, Progress and Priorities Report, (March 2008) ["DSC 2008 Report"],* TAB 221 BOD VOL 8.

[377] *Task Force on Technical Compensation, Report to the Diagnostic Services Committee, (March 19, 2008),*TAB 222 BOD VOL 8.

Table: Task Force on Technical Compensation (TFTC) Summary of Costs for Sample Fee Codes [378]

Fee Code	2008 Fee[3]	CR IHF GTA	CR IHF Other Ontario	CR Academic Hospital	CR General Hospital	DR IHF GTA	DR IHF Other Ontario	DR Academic Hospital	DR General Hospital
X091	$22.45	$65.03	$60.62	$67.26	$55.77	$64.83	$61.30	$78.44	$67.64
X113	$62.85	$113.72	$105.65	$116.82	$97.74	$130.76	$124.44	$161.38	$142.99
X185	$38.10	$92.41	$90.57	$91.50	$79.14	$122.41	$121.66	$115.75	$103.86
X224	$23.50	$75.54	$70.03	$77.31	$64.63	$74.95	$70.58	$91.58	$79.79

Fee Code	Current Fee	IHF GTA	IHF Other Ontario	Academic Hospital	General Hospital
J135	$50.00	$77.50	$66.24	$90.28	$74.83

B. Further Deterioration since 2008

8. This chronic underfunding has continued to grow with no adjustment over the last two decades despite significant increases in labour, facility and consumable costs. In addition, many of these services have incorporated new technologies that require large investments to maintain acceptable standards of care, such as new PACS/RIS/IT support.

9. To provide a global evaluation of the cost of performing diagnostic services subsequent to the 2008 work of the DSC, the OMA constructed two Technical Fee Medical Economic Indices (TFMEI) (see Table 2 below).

10. The first index (TFMEI-1) is based on expense components for staff salary, office rent/lease, and supplies and equipment, where the component weightings are based on figures presented in TFTC's March 19, 2008 report to the DSC.

11. The second index (TFMEI-2) adds other medical expenses to the components of the TFMEI-1. The weighting of each component is also different and is based on figures presented in the Medicare RBRVS: The Physicians' Guide 2017. [379]

12. Both indices demonstrate that the cost of performing diagnostic services has risen since 2006: by 46% according to the TFMEI-1 and by 36% according to

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[378] *X091 X-ray - Chest, two views; X113 X-ray - Colon - air contrast, primary or secondary, including survey films, if taken; X185 Mammogram – bilateral; X224 X-ray - Knee including patella, three or four views; J135 Diagnostic Ultrasound - Complete abdominal scan; CR - Computed Radiography; DR – Digital Radiography.*

[379] *American Medical Association, Medicare RBRVS: The Physicians' Guide 2017, (American Medical Association, 2017), pp. 49-53.*

the TFMEI-2.

Table: Technical Fee Medical Economic Index - 1 (TFMEI - 1)

Year	Expense Component			TFMEI*	Index (2006=100)
	Staff Salary	Office Rent	Supplies/ Equipment		
2006	3.0%	3.6%	1.8%	**2.44%**	100.0
2007	.7%	1.9%	1.6%	**5.00%**	105.0
2008	15.5%	2.3%	3.9%	**8.70%**	114.1
2009	12.4%	9.1%	1.5%	**6.70%**	121.8
2010	2.1%	-3.3%	3.5%	**2.38%**	124.7
2011	5.3%	2.9%	8.0%	**6.44%**	132.7
2012	1.4%	0.8%	0.9%	**1.12%**	134.2
2013	3.6%	-0.5%	2.5%	**2.70%**	137.8
2014	3.9%	0.3%	1.7%	**2.51%**	141.3
2015	2.0%	1.5%	1.5%	**1.71%**	143.7
2016	2.7%	0.3%	0.3%	**1.29%**	145.6

** TFMEI-1 weightings: 42.2% staff, 7.8% for office rent, 50.0% for medical equipment and supplies. The weightings of each expense component are based on the Task Force on Technical Compensation, Report to the DSC – March 19, 2008, that identified six cost components with significant impact on total technical fee costs. The median proportion was used and expected return on investment was excluded.*

Sources

Component	Base Index	Source
Staff Salary	Avg Earnings - Office of Physicians	CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians
Office Rent	Rental Rate	Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates
Supplies/Equipment	Supplies/Equipment	CANSIM, Canada; medical equipment and supplies manufacturing

Table: Technical Fee Medical Economic Index - 2 (TFMEI - 2)

Year	Expense Component				TFMEI*	Index (2006=100)
	Staff Salary	Office Rent	Other Expenses	Supplies/ Equipment		
2006	3.0%	3.6%	2.1%	1.8%	**2.43%**	100.00
2007	9.7%	1.9%	1.3%	1.6%	**3.86%**	103.86
2008	15.5%	2.3%	1.9%	3.9%	**6.64%**	110.76

2009	12.4%	9.1%	1.0%	1.5%	**5.51%**	116.86
2010	2.1%	-3.3%	1.9%	3.5%	**1.90%**	119.08
2011	5.3%	2.9%	2.1%	8.0%	**5.36%**	125.46
2012	1.4%	0.8%	0.7%	0.9%	**1.00%**	126.72
2013	3.6%	-0.5%	0.5%	2.5%	**2.01%**	129.27
2014	3.9%	0.3%	1.6%	1.7%	**2.12%**	132.00
2015	2.0%	1.5%	0.9%	1.5%	**1.53%**	134.02
2016	2.7%	0.3%	1.8%	0.3%	**1.27%**	135.73

** TFMEI-2 weightings: 28.6% staff, 13% for office rent, 20.3% for other expenses and 38.2% for medical equipment and supplies. The weightings of each expense component are based on the Medicare RBRVS: The Physicians' Guide 2017, Table 5·2. Mean Practice Expenses per Hour Spent in Patient Care Activities for Independent Diagnostic Testing Facilities.*

Sources

Component	**Base Index**	**Source**
Staff Salary	Avg Earnings - Office of Physicians	CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians
Office Rent	Rental Rate	Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates
Other Expenses	CPI & Pharmaceuticals	1. CANSIM, Consumer price index (CPI), 2005 basket content, Ontario; all-items; 2. CANSIM, Canada; pharmaceutical and medicine manufacturing
Supplies/Equipment	Supplies/Equipment	CANSIM, Canada; medical equipment and supplies manufacturing

C. Technical Fees in Absolute Terms Have Decreased

13. Over the past 19 years, technical fees have not only failed to keep pace with the increasing costs of providing diagnostic services but have actually decreased in absolute terms by 0.05%.

14. This decrease does not include the additional reduction in technical fees following the Ministry's unilaterally imposed across-the-board payment discounts that have continued since 2012 and now total -4.45%, thereby compounding the problem.

15. The following (Table 3) summarizes technical fee payment changes since

1998:

Table: Technical Fee Changes: 1998 – 2017

Cumulative Technical fee adjustments (1998-2017) = -0.05%

Year	% Change to SOB	Additional Ongoing Discounts	Notes
1998			
1999	1.45%		
2000			
2001			
2002			
2003			
2004			
2005	1.00%		April 1, 2005: 1% ATB ("across-the-board")to tech fees
2006			
2007			
2008			Interim one-time funding (approximately 2%) from 2008 to 2012, unilaterally terminated in 2012
2009			
2010			
2011			
2012	-2.50%		MOH unilaterally terminates interim funding, and further imposed 2.5% technical fee decrease
2013		ATB: -0.5%	April 1, 2013 - 0.5% Payment discount applied to all FFS claims
2014			
2015		ATB: -3.15%, increased October 1, 2015 to -4.45%	Add'l FFS Payment unilateral discounts: (1) February 1, 2015 - 2.65% (T=3.15%) (2) October 1, 2015 - 1.3% (T=4.45%)
2016			Unilateral discount continues
2017			Unilateral discount continues

III. Developments since 2017

749. Since 2017, the gap between actual costs and expenses and the limited amounts provided under the OHIP Schedule to reimburse physicians for these technical fee costs and expenses has only widened.

750. Moreover, despite the direction in the 2017-21 PSA arbitration award, and the more recent bilateral commitment to address technical fee compensation as a priority matter, the history of the parties' attempts to engage bilaterally on improving compensation for technical fees shows that the Ministry has no interest in addressing this matter.

751. The table immediately below presents an evaluation of the cost of performing diagnostic services since 2007 based on OMA constructed Technical Fee Medical Economic Indices ("TFMEI"). Both indices demonstrate that the cost of performing diagnostic services has risen since 2007, by 56.7% according to the TFMEI-1 and by 42.2% according to the TFMEI-2, as follows:

Table: Technical Fee Medical Economic Indices ("TFMEI"): 2007 - 2022

	TFMEI – 1					TFMEI - 2				
Year	Expense Component			TFMEI*	Index	Expense Component			TFMEI*	Index
	Staff Salary	Office Rent	Supplies/ Equipment			Staff Salary	Office Rent	Supplies/ Equipment		
2007	9.7%	1.9%	1.8%	5.1%	100.0	3.9%	1.9%	1.8%	2.7%	100.0
2008	15.5%	2.3%	2.8%	8.2%	108.2	2.6%	2.3%	2.8%	2.7%	102.7
2009	12.4%	9.1%	2.1%	7.0%	115.8	2.0%	9.1%	2.1%	2.6%	105.4
2010	2.1%	-3.3%	9.4%	5.3%	121.9	3.7%	-3.3%	9.4%	6.0%	111.8
2011	5.3%	2.9%	2.6%	3.7%	126.5	1.2%	2.9%	2.6%	2.0%	114.0
2012	1.4%	0.8%	1.2%	1.3%	128.1	1.4%	0.8%	1.2%	1.3%	115.4
2013	3.6%	-0.5%	2.0%	2.5%	131.3	1.7%	-0.5%	2.0%	1.7%	117.4
2014	3.9%	0.3%	1.4%	2.3%	134.3	2.0%	0.3%	1.4%	1.5%	119.2
2015	2.0%	1.5%	2.1%	2.0%	137.0	2.7%	1.5%	2.1%	2.3%	121.9
2016	2.7%	0.3%	-0.9%	0.7%	138.0	1.3%	0.3%	-0.9%	0.1%	122.1
2017	-0.1%	1.9%	0.4%	0.3%	138.4	1.8%	1.9%	0.4%	1.1%	123.4
2018	4.0%	3.3%	2.0%	2.9%	142.5	2.9%	3.3%	2.0%	2.4%	126.4
2019	3.9%	4.3%	0.3%	2.1%	145.6	2.7%	4.3%	0.3%	1.6%	128.5
2020	3.7%	1.1%	-0.5%	1.4%	147.6	7.2%	1.1%	-0.5%	2.9%	132.2
2021	0.4%	3.4%	3.4%	2.1%	150.8	3.5%	3.4%	3.4%	3.5%	136.8
2022	2.2%	0.3%	6.0%	3.9%	156.7	2.2%	0.3%	6.0%	3.9%	142.2

* To calculate TFMEI - staff salary component is given a 42.2% weighting, 7.8% for office rental expense and 50% for medical equipment and supplies.

Weighting of the TFMEI is based on the Task Force on Technical Compensation, Report to the DSC – March 19, 2008, that identified six cost components with significant impact on total technical fee costs. The median proportion was used and expected return on investment was excluded.

Sources:

Component	Base Index	Source
Staff Salary – TFMEI 1	Avg Earnings - Office of Physicians	CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians
Staff Salary - TFMEI 2	Average Weekly Earnings - Ontario Industrial Aggregate Index	CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; industrial aggregate excluding unclassified businesses
Office Rent	Rental Rate	Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates
Supplies/ Equipment	Supplies/ Equipment	CANSIM, Canada; medical equipment and supplies manufacturing

752. The following table presents technical fee increases since 2007. Over the past 15 years, technical fees have failed to keep pace with the increasing costs of providing diagnostic services and have only increased in absolute terms by 2.98%, as follows:

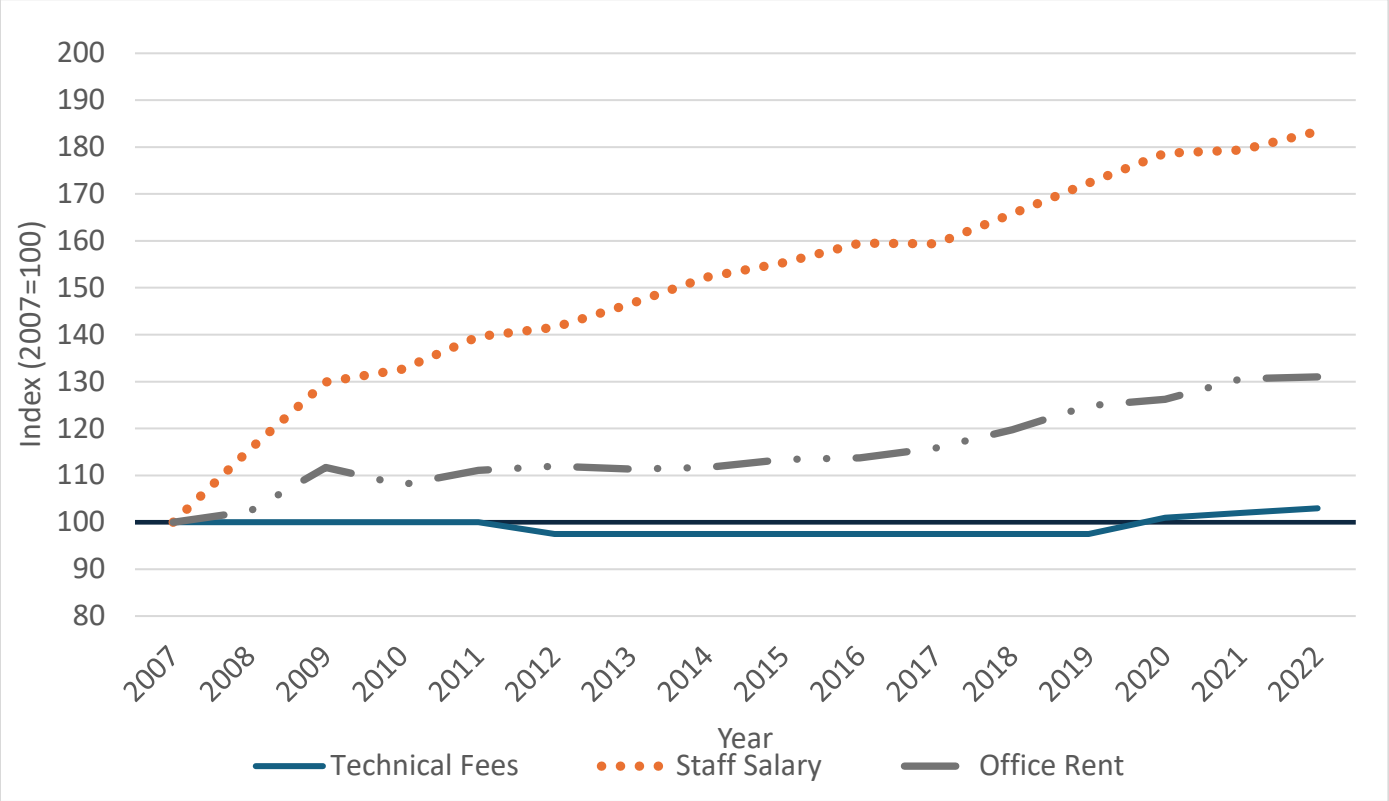
Table: Technical Fee Changes: 2007 – 2023

Year	% Change	Discounts	Comments
2007		H Fee: 7.0%	
2008		H Fee: 7.0%	
2009		H Fee: 7.0%	
2010		H Fee: 7.0%	
2011		H Fee: 7.0%	
2012	-2.50%	H Fee: 7.0%	MOH imposed 2.5% technical fee decrease
2013		H Fee: 7.0% ATB - 0.5%	April 1, 2013 - 0.5% Payment discount applied to all FFS claims
2014		H Fee: 7.0% ATB - 0.5%	
2015		H Fee: 7.0% ATB - 3.15% ATB - 4.45%	Add'l FFS Payment discounts: (1) February 1, 2015 - 2.65% (T=3.15%) (2) October 1, 2015 - 1.3% (T=4.45%)

2016		H Fee: 7.0% ATB - 4.45%	
2017		H Fee: 7.0%	* 0.75% global payment increase (excluding only hospital technical fees and OPIP)
2018		H Fee: 7.0%	* 1.25% global payment increase (excluding only hospital technical fees and OPIP)
2019		H Fee: 7.0%	* 0.5% global payment increase (excluding only hospital technical fees and OPIP) * 0.5% used to remove the 0.5% payment discount from the 2012 PSA* * Elimination of the unilateral 2015 2.65% non-fee for service and 3.95% fee-for service payment discounts
2020	3.54%	H Fee: 7.0%	* 1.0% global payment increase (excluding only hospital technical fees and OPIP) * All technical services will receive a fee increase of 3.54% with the exception of technical services performed in hospital
2021		H Fee: 7.0%	* 1% global payment increase (excluding only hospital technical fees and OPIP)
2022		H Fee: 7.0%	* 1% global payment increase (excluding only hospital technical fees and OPIP)
2023	2.01%	H Fee: 7.0%	* 2.01% permanent increase to SOB, effective April 1, 2023 (reflects compounded value of FY2021/22 & FY2022/23 global payment increases).

753. The following figure presents the change in staff salary and office rent expenses, compared to the changes to non-hospital technical fee values for diagnostic services since 2007. Over the past 15 years, technical fees have increased by about 3%, while staff salaries have increased 83% and office rents have increased 31%.

Figure: Technical Fees vs Medical Expense Components, 2007-2022 (Based on Schedule Values - Unilateral Action Removed)



Notes:

Hospital technical fees excluded from analysis.

For simplicity, figure does not take into account unilateral discounts from 2013-2015 and subsequent reversal of these discounts.

Sources:

CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians

Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates

IV. 2021 Beltzner Study on costs associated with technical fees

754. In 2021 the OMA side of the Technical Fees Working Group ("TFWG") commissioned a study on an approach to evaluate the current cost of providing the technical component of a service in Ontario (report completed in 2022). The accountant selected to complete this report, Mr. Rainer Beltzner (an expert in medical expenses and cost accounting) is the former chair of the Task Force on Technical Compensation that reported to the trilateral Diagnostics Services Committee (as referred to above).

755. While the 2021-22 Beltzner study worked to establish a costing methodology that could apply broadly to the range of technical services in Ontario, six technical services were fully costed using real world data as a proof of concept. Comparing these values to actual amounts paid for these services provides an understanding of how technical services are funded relative to the cost of providing those services.

756. Of the $992M in diagnostic technical fees billed in FY2019, Diagnostic Radiology and Cardiology account for approximately 72% of this total, by dollar value. On this basis, the TFWG decided to select two (2) codes primarily billed by Diagnostic Radiology and two (2) billed primarily by Cardiology for study. The remaining two (2) codes were selected from the common technical codes billed by other Specialties. The selection of individual technical fee codes was further informed by the following criteria:

i) The fee codes selected should be commonly billed and representative of the work typically performed (measured by total payments, service volume, number of physicians, and patient counts).
ii) Fee codes should be selected that are billed in a variety of care settings (i.e., Independent Health Facility ("IHF"), Hospitals, and private office settings).
iii) Codes should be selected from different Specialties (noting that not all specialities that bill technical fees can be included in this limited pilot study).
iv) Codes should have well defined equipment and quality standards.

757. In the OMA-TFWG's report, Mr. Beltzner provides the following commentary:

> *"Current costs per procedure are higher than the approved technical fees. The most significant cost increases come from the current cost of technologists (and to some extent the support admin staff) where wage rates have seen significant upward pressures due to the current competitive environment. This is unlikely to change in the future until more technologists enter the market. Diagnostic equipment has seen increases particularly with respect to cost of repair, maintenance, and software version upgrades. While many peripheral devices (servers, PC's, etc) have seen cost reduction because of a competitive environment, this is offset by the increased need for system integration, security, and the supporting skill set to support an increasingly complex environment […]"*

The table below shows the difference between the estimated incremental costs of providing a technical service and the technical fee associated with that same service (as of 2022).

Table: Selected Fee Codes: Technical Fees and Estimated Cost of Provision (2022)

Code	Descriptor	Technical Fee (February 2022)	Estimated Cost (February 2022)
G570A	Echocardiography - Complete study - 1 and 2 dimensions - technical component	116.60	118.00
J135B	Diagnostic Ultrasound - Thorax, abdomen and retroperitoneum - Abdominal scan - Complete	50.50	88.01
X091B	Diagnostic Radiology - Chest & Abdomen - Chest - Two views	24.40	37.37
G315A	ECG - Stress Testing - Maximal stress ECG - technical component	45.05	77.51
J310B	Pulmonary Function Studies - Functional residual capacity - Carbon monoxide diffusing capacity by single breath method	22.15	28.48
G455A	Physical Medicine - Needle electromyography and nerve conduction studies - Schedule A - technical component	28.35	79.35

758. The following table shows the “full” procedural costs. The full procedural costs view the procedure as a stand-alone procedure. This would apply if a new clinic was built and equipment bought from scratch, and only used to perform a given procedure. If a new clinic was created, with new equipment, etc., there would not be any question that there would be a substantial loss for a few years.

Table: Full procedural costs associated with provision of select technical services (2022)

	G570A	J135B	X091B	G315A	J310B	G455A
Equipment	$26.50	$34.38	$10.31	$11.83	$4.47	$12.40
Personnel	$76.08	$49.06	$21.66	$56.88	$19.74	$61.91
Space	$37.10	$24.53	$8.22	$40.60	$8.45	$9.32
Other	$14.56	$8.01	$9.16	$9.72	$4.72	$9.75
Total Current Cost Per Procedure	$154.23	$115.98	$49.35	$119.04	$37.38	$93.98
T-Fee Per	$116.60	$50.50	$24.40	$45.05	$22.15	$28.35
	$37.63	$65.48	$24.95	$73.99	$15.23	$65.03

Difference Per Procedure	31%	130%	102%	164%	69%	229%

759. The next table shows the 'incremental' procedural costs - i.e. if the procedure was added to an already existing operating facility.

Table: Incremental procedural costs associated with provision of select technical services (2022)

	G570A	J135B	X091B	G315A	J310B	G455A
Equipment	$20.31	$31.30	$9.43	$8.12	$3.65	$9.65
Personnel	$70.43	$43.41	$16.01	$50.32	$17.51	$53.39
Space	$12.71	$5.30	$2.77	$9.35	$2.99	$6.57
Other	$14.56	$8.01	$9.16	$9.72	$4.34	$9.75
Total Current Cost Per Procedure	$118.00	$88.01	$37.37	$77.51	$28.48	$79.35
T-Fee Per	$116.60	$50.50	$24.40	$45.05	$22.15	$28.35
Difference Per Procedure	**$1.40** 1%	**$37.51** 74%	**$12.97** 53%	**$32.46** 72%	**$6.33** 29%	**$51.00** 180%

760. More details on costing methodology and cost elements can be found in the TFWG's report, "Cost of Selected Technical Fee Codes: Pilot Study" and "Cost of Selected Technical Fee Codes: Scalable Approach".[380]

[380] Technical Fee Working Group Report, "Cost of Selected Technical Fee Codes: Pilot Study" and "Cost of Selected Technical Fee Codes: Scalable Approach". TAB 223 BOD VOL 8.

V. OMA Technical Fees Proposal

761. The OMA proposes that technical fees (including Integrated Community Health Service Centre facility costs) be increased to cover the cost of providing diagnostic services and procedures, to allow for future investment in new equipment and to encourage the use of technologies that best serves the needs of Ontario patients.

762. In each year of the 2024-2028 PSA, beginning in Year 1, the OMA proposes a 10% increase to the OHIP technical fee pool, including hospital Emergency Department and Out Patient Department technical fees, physician technical fees and ICHSC facility costs, to be implemented through the Physician Services Committee ("PSC") based on recommendations provided by the Physician Payment Committee ("PPC").

763. The 10% annual increase to the technical fee pool would be allocated on the following basis: 25% of funds will be applied to new technologies and 75% of funds will support an adjustment of existing diagnostic services and procedures, taking into consideration advances in technology and overall cost increases.

a) Bilateral Technical Fee Committee

764. The OMA proposes that the parties established a joint MOH-OMA technical fee committee ("TFC") under the auspices of PPC. The TFC would be responsible for developing a framework to ensure that there is an appropriate level of technical and facility fees in order to cover the cost of providing diagnostic services and procedures.

765. The committee's mandate would include determining and recommending to PPC appropriate compensation for the provision of the technical component (including facility costs) of diagnostic and procedural services. In addition, the committee would address system issues such as a planning, quality and service standards, appropriateness, the introduction of new services and technologies and the acquisition and replacement of capital equipment.

b) PPC Role

766. The OMA proposes that the PPC employ the following framework for the timely introduction of funding to support existing and new diagnostic services and procedures:

1. If the request is for a new fee, the PPC must first recommend the corresponding professional fee. The Section must indicate on the Professional Fee Assessment Form (“PFAF”) if there is an accompanying technical fee. It is not necessary to provide a completed Technical Fee Assessment Form (“TFAF”) with the initial submission.

2. If the request is for a revision of an existing fee, it should be submitted as part of the PPC fee setting/allocation process. The Section cannot present a request to the Technical Fee Committee (“TFC”) directly.

3. If the PPC feels the request is warranted, it is forwarded to the TFC for determination of an appropriate fee.

4. Sections submit their TFAF and supporting documentation to the TFC.

5. Sections present their request(s) to the TFC.

6. TFC submits its recommendations to PPC for final deliberation and inclusion in the PPC final recommendation to the PSC.

H. ADMINISTRATIVE BURDEN

I. Backgound

I. As discussed above at paragraphs 494-496, administrative burden in medicine is linked to rising rates of burnout among physicians – and while the impact on family medicine is severe, the concerns apply across the profession.

J. Indeed, mounting paperwork is a challenge across the profession. According to the Canadian Medical Association's 2021 National Physician Health Survey ("NPHS"),[381] family physicians are significantly more likely (61%) to say that the time they spend on Electronic Medical Records ("EMR") at home is "excessive" or "moderately high" compared to their specialist colleagues (39%).

K. The Canadian Federation of Independent Business 2023 "Patients Before Paperwork" report[382] revealed that Canada's doctors spend approximately 18.5 million hours on unnecessary paperwork and administrative tasks each year—the equivalent of 55.6 million patient visits annually. These findings underscore the critical issue of the physician administrative burden and the detrimental effects it has on our health care system.

L. In 2021, the OMA found that almost three-quarters of physicians are experiencing burnout, with 35% of physicians feeling high levels of burnout or complete burnt out. Ontario physicians identified that streamlining and reducing required documentation and administrative work was their highest priority solution to addressing this burnout.

M. As noted above, the Ontario College of Family Physicians ("OCFP") identified that family doctors report spending significant hours each week on administration – most of which is unpaid and unnecessary. 94% said they are overwhelmed with administrative tasks, and a full day of clinical work results in up to an additional five hours spent on administrative work.

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[381] CNA *National Physician Health Survey. 2021, supra* at p. 17, TAB 18 BOD VOL 1.
[382] CFIB Paperwork, *supra,* TAB 28, BOD VOL 1.

II. OMA Proposal

772. The impacts of administrative burden are numerous: reduced time for patient care, physician burnout, increased physician and system costs, delayed access to care, reduced physician and patient satisfaction.

773. Efforts to reduce the administrative burden on physicians are crucial to mitigating these negative impacts. By streamlining administrative processes, implementing technology solutions and adopting health care system improvements, it is possible to improve the overall health care experience for both physicians and patients.

774. Doctors of BC's burdens solutions framework[383] serves as an important guide in considering how to address administrative burden. First and foremost, unnecessary burdens should be eliminated entirely. If they cannot be eliminated, they should be simplified, undertaken by the most appropriate health care provider, and most importantly for the purpose of this arbitration, fairly compensated.

775. In Nova Scotia, more than 45 initiatives have been identified, many completed, others underway, to reduce physician red tape by 400,000 hours per year, the equivalent of 1.2 million patient visits, by the end of 2024.

776. The OMA proposes that the Ontario Government commit to reducing unnecessary administrative burden on physicians by 1,000,000 hours. Possible actions could include: reducing burden from the credentialing process (e.g., regional credentialing), elimination of duplication of test results, implementing a centralized intake and referral process, improving the pharmacy Limited Use process, eliminating the need for sick notes.

777. A publicly available scorecard similar to what is in place in Nova Scotia can be used.[384]

778. However, for administrative burden that cannot be eliminated the OMA proposes funding for indirect services at an hourly rate of $171.05 per hour, billable in 15-minute increments ($42.76 per 15 minutes) up to a maximum of 3 hours per week available to all

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[383] Doctors of BC, "Addressing Physician Burdens," TAB 224 BOD VOL 8.
[384] Government of Nova Scotia, "Actions to reduce unnecessary administrative burdens for Nova Scotia's doctors," (November 2023), TAB 225 BOD VOL 8.

physicians. This fee code would be limited to non-billable services (both insured and non-insured). Examples of indirect services are:

A - Completion of clinically required requests, forms and reports.

B - Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g., investigating particular diagnostic and therapeutic interventions).

III. Administrative Burden – MedsCheck and Minor Ailment Report Fee

779. Under the government's MedsCheck program, pharmacists are eligible to submit a $60 annual MedsCheck per patient (plus additional $25 follow-ups).

780. As part of the MedsCheck:

A.1 - The results of any MedsCheck, including a personal medication history, is shared with the patient/caregiver and with their physician and/or primary health care provider.

A.2 - All potential drug therapy problems identified during the MedsCheck must be resolved or have a plan for resolution prior to providing the completed MedsCheck Personal Medication Record to the patient and primary health care provider.

781. Furthermore, according to the MedsCheck guidelines, pharmacists have the discretion to do further research and assessment, which can in turn create further administrative burdens for physicians.

782. In addition to MedsCheck, as of January 1, 2023, pharmacists in Ontario are authorized to prescribe medications for 13 minor ailments. Pharmacists who do so are required to notify a patient's family physician within a reasonable time to "support continuity of care and positive treatment outcomes."

783. From the perspective of the physician, these programs have created an increased uncompensated burden for physicians. Pharmacists who complete a MedsCheck send a notification form to the physician. This is done both when drug therapy issues are

identified and follow-up is required by the physician, as well as when no drug therapy issues are identified and thus no follow-up is needed by the physicians.

784. Physicians receive a very high volume of MedsCheck foms and Minor ailment reports, on average ranging from 1 to 5 daily. These reports can be up to several pages long and may take 10 minutes or longer to review each time one is received. The physician (mainly family physicians) is required to review all of it as part of their professional responsibilities. Whether the report is informative or not, it must be reviewed for content, accuracy, clinical appropriateness, any intervention/concerns that require physician action, and it must be integrated into the patient's medical chart. This creates both an unpaid administrative task as well as additional medicolegal responsibility/liability.

785. As a result, the OMA proposes to create a $25 fee for physicians receiving and reviewing pharmacists MedsCheck and Minor Ailment report for each report or MedsCheck received.

I. TARGETED FUNDING TO SUPPORT IMPROVEMENTS TO VIRTUAL CARE

786. Following the shift to virtual care compelled by the pandemic, and the resulting recognition of the appropriateness of physicians providing ongoing virtual care on an ongoing basis, the 2021-24 PSA introduced a permanent framework for the payment of virtual care services in Ontario (Section B of the 2021-24 PSA).

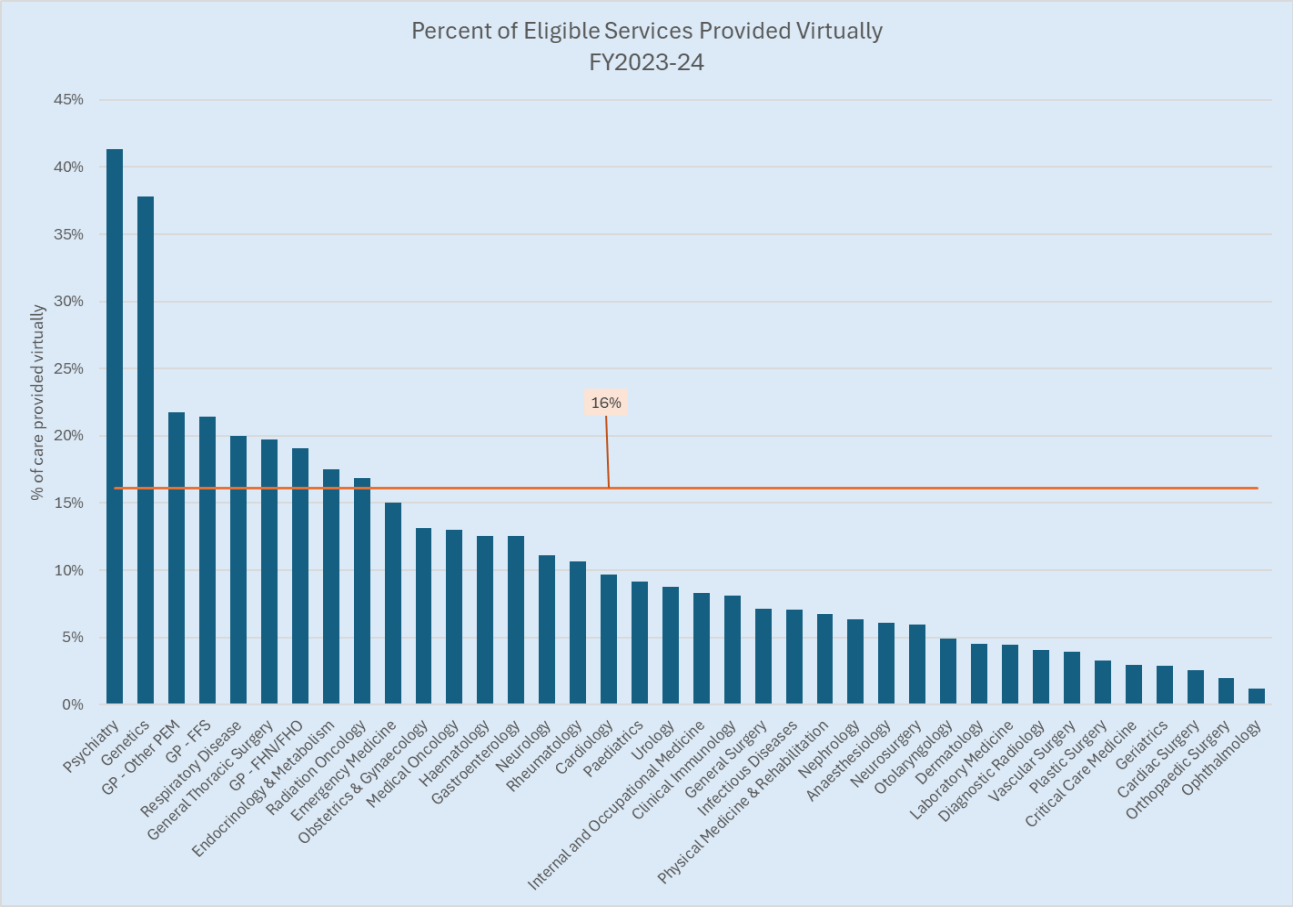
787. This framework integrates video and telephone under the OHIP insured framework, establishing a basket of services that may be delivered virtually when clinically appropriate. It also emphasizes the importance of providing virtual care in the setting of an ongoing physician-patient relationship, which is referred to as comprehensive virtual care.

788. Prior to ratification of the 2021 PSA, the OMA and the ministry committed to considering, and, where appropriate, addressing situations where pre-pandemic access to virtual services through the Ontario Telemedicine Network (“OTN”) could be unintentionally limited under the PSA. The parties agreed to do so prior to the implementation of the new virtual codes.

789. Notably, in June 2022, when the OMA shared certain member concerns with the Ministry of Health, prior to the implementation of the virtual care framework, the Ministry responded that these issues would need to be part of the next round of bargaining if any additional changes were to be made.

790. The OMA is now seeking to remove barriers for provisions of virtual services that may have been excluded, unintentionally or otherwise, from the framework in the 2021 PSA, as well as to improve access to virtual care.

791. If the restrictions on access to virtual care that the OMA has identified as barriers were initially imposed because of a concern that there would be excessive virtual care provided as we emerged from the pandemic, the evidence is entirely to the contrary. The concern that there would be a disproportionate degree of virtual care service provided following the pandemic, and under the new virtual care payment framework, has been rebutted by the actual experience. For 2023-24, only 16% of service eligible to be provided both in person and virtually have been provided virtually.



792. As a result, given the demonstrated appropriateness of virtual care being provided to patients by Ontario physicians, the OMA now proposes the removal of the following restrictions on payment for virtual care services provided by physicians (and therefore removal of restrictions or barriers on access by patients to virtual care services).

I. Virtual Care by Telephone

793. The OMA proposes to enable the appropriate use of telephone care where video may not be feasible due to cost, technology, patient knowledge, and other reasons. Indeed, video has become a barrier to receiving care for many groups, including those who are simply not able to utilize video technology. To address this issue, the OMA proposes:

(a) Increasing the rate for delivery of comprehensive virtual care services by telephone from 85% (95% for certain mental health services) to 100% of in person services.

(b) Allowing physicians to bill for comprehensive virtual care consultations conducted by telephone when unable to perform a video or conduct an in-person consultation.

794. Notably with the exception of Saskatchewan (which reimburses virtual telephone care at 90% of the fee schedule amount), other provinces pay for virtual care by telephone on par, i.e. without a 15% reduction imposed on what is defined in Ontario as comprehensive virtual care services.

II. Enable Physicians Practicing in Shared Care Models to Bill Comprehensive Virtual Care Codes

795. Under the PSA 2021-24 rules for being reimbursed for providing comprehensive virtual care, there must be an existing/ongoing patient-physician relationship. This has meant that, where physicians provide shared care as a group, unless a particular physician who is part of that shared care team has an existing/ongoing patient-physician relationship (defined as the patient having had at least one insured service with a direct physical encounter with that physician in the preceding 24 months), that physician cannot be reimbursed for providing comprehensive virtual care.

796. This type of shared care was previously allowed for all physicians as part of the Ontario Telemedicine Network, under the pre-Covid Virtual Care Program rolled out November 15, 2019 and under the COVID virtual care compensation agreement.

797. There are many examples of shared-care practice models including:

- Community Palliative Care On-Call Program which provides 24 / 7 / 365 care to palliative patients in Ontario;
- The Ottawa Hospital’s renal transplant and glomerulonephritis clinics;
- London-based community clinic for diabetes in pregnancy (GDM, Type 1, Type 2, other endocrine disease);
- Toronto practice for obesity medicine with multiple sites;

- Ottawa-based Rapid Referral Cardiac Clinic provides virtual urgent assessments in lieu of admission or ED. The clinic also follows patient closely after discharge to avoid readmission or return to ED;

- General internal medicine physician group providing OB medicine focused on treating patients with medical complications in pregnancy. Initial visits are in person with one physician but follow ups are virtual and may be undertaken by another physician in the group.

798. Moreover, the OHIP Schedule payment rules specifically allow for specialists and GP Focus Practice Physicians in the same practice group to fulfill the separate requirement to provide availability for direct physical encounters in order to be eligible to be paid for comprehensive virtual care. Specifically, the OHIP Schedule states:

> *9. Services involving a direct physical encounter must be made available by the physician providing Comprehensive Virtual Care Services, or by the physician's group, within a clinically appropriate time-frame, if it becomes apparent during a Virtual Care Service that a service involving a direct physical encounter is medically necessary, or if at the time of scheduling the service the patient expresses preference for a service involving a direct physical encounter." [A65]*

799. The OHIP Schedule further defines "a group", in commentary, as follows:

> *"For the purpose of this provision, with respect to specialist and GP Focused Practice Physicians, a group is defined as: those physicians in the same hospital specialty call rotation, or who are co-located in shared clinical physical space, and have shared access to the patient's medical record. For family and general practice physicians, a group is defined as: Patient Enrollment Model physicians who are signatory or contracted to the same specific group contract (i.e., as identified by the same group billing number), or those physicians who are co-located in a shared clinical physical space and have shared access to the patient's medical record." [page A65]*

800. However, the terms of the new Virtual Care Framework under the 2021-24 PSA unjustifiably restrict reimbursement for virtual care when provided in shared care models by specialist and GP Focus Practice Physician groups. For their part, family medicine physicians in a Patient Enrolment Model were not similarly impacted.

801. In the OMA's view, allowing specialists and GP Focus Practice Physicians practicing in shared care models to bill comprehensive virtual care codes would enhance patient access and comprehensive care and decrease wait time for services. It would also reduce the number of consultations claimed for the purposes of establishing a physician-patient relationship.

802. As a result, the OMA proposes to enable physicians practicing in shared care models to bill comprehensive virtual care codes, as follows:

> *Modify the OHIP Schedule to allow for comprehensive virtual care codes where specialists and GP Focus Practice Physicians (both GPP and GPFP) work in a comprehensive group practice.*
>
> *Shared care payment criteria defined as: An established physician-patient relationship with another physician within the same practice group who has provided at least one insured service to the patient in the preceding 24 months, and the physician has access to the patient's medical record.*
>
> *Same practice group is defined as: Physicians within the same specialty/GP Focus Practice designation, or who work together in multidisciplinary clinics focused on a shared condition or pathology (e.g. thrombosis, hand, burns and spine clinics), and who are available to provide direct physical encounter coverage. The practice group must have been designated by the MOH and has received shared care group number.*
>
> *Furthermore, locum tenens replacing an absent physician in the absent physician's office may bill comprehensive virtual care codes on the absent physician's patients and would be treated as a member of the practice group during the duration of placement.*
>
> *<u>Claims Submission Requirements:</u> Claims for comprehensive virtual care codes in a MOH designated practice group must be submitted using the designated practice group number. For claims payment purposes, the MOH designated practice group number must be submitted on the claim.*

III. Case Conferencing

803. The OMA proposes to revise existing rules for case conferencing to allow case conferencing between two health care providers, including between a physician and one allied health professional (this proposed improvement would apply to both in person and virtual services).

804. Case conference services currently cannot be billed to OHIP without a physician and two other participants. However, there are many situations where it is appropriate to involve the physician and only one other participant. If the physician is spending time (minimum 10 minutes) discussing the management of a patient, the number of participants should not be determinative. The management of the patient is the key, not the number of persons discussing same.

805. Moreover, in more complex cases, the physician may be speaking to another participant for 30-40 minutes; physicians should be compensated for this time, as it contributes to quality patient care.

806. For their part, long term care physicians are also only eligible to bill case conference fees virtually (K124 and K705) where there are two or more other participants. Reducing criteria to one or more other participants would improve access and co-ordination of care for complex LTC patients which could, in turn, reduce number of LTC patient transfers to hospital.

807. In other Canadian provinces that have case conference fee codes, there is no minimum number of participants.

IV. Long-Term Care Virtual Care Services

808. The OMA proposes to modify the OHIP Schedule to allow comprehensive virtual care codes to be billed for non-elective virtual care service encounters in long term-care facilities, under the following requirements:

> • *Non-elective virtual care encounters is a visit initiated by a patient or an individual on behalf of the patient (e.g., staff of the institution) for the purpose of rendering a non-elective service, e.g. similar criteria as billing a special visit premium.*
>
> • *Virtual care can only be conducted by a physician who is affiliated to the LTC home.*
>
> • *Non-elective virtual care encounters are only eligible for payment evenings (17:00h – 24:00h) Monday to Friday, or daytime and evenings on Saturdays, Sundays, Holidays, or nights (00:00h – 07:00h), or if rendered during daytime hours (07:00 -17:00 hrs Monday through Friday) requiring sacrifice of office hours.*
>
> • *Non-elective virtual care encounters do not count towards W010 visit requirements.*

809. In the OMA's view, this would improve access and co-ordination of care to LTC patients for acute episodic episodes, improve patient access for timely non-elective services in LTC facilities, and help reduce unnecessary LTC transfers to emergency departments, reducing, in turn, emergency department wait times.

810. LTC physicians are currently eligible to bill a special visit premium plus the applicable visit fee when requested to see a patient for a non-elective service. Allowing these cases, where appropriate and in accordance with CPSO standards, to be provided virtually would improve timely access to care and could also result in cost-savings.

J. TARGETED FUNDING FOR OVERHEAD EXPENSES

811. While both community-based and hospital-based physicians incur overhead costs, community practices often face additional challenges due to their smaller scale, lack of institutional support, and competitive market dynamics. Managing these overhead costs effectively is essential for community physicians to maintain financial sustainability while providing quality care to their patients.

812. Running a physician's office involves various expenses beyond just the direct costs of providing medical care. These additional costs can significantly impact the overall expenses of the practice.

813. Expenses include, but are not limited to, administrative staff, office space, medical equipment and supplies, office equipment, all of which are the responsibility of the community physicians.

814. Numerous provinces have introduced a “Business Cost” fee that is in recognition of this additional overhead, as follows:

> *<u>British Columbia Business Cost Premium</u>*
> *British Columbia offers the Business Cost Premium (BCP) which is a payment to help eligible physicians cover the rising rent, lease, or ownership costs of a community-based office.*
>
> *The BCP is a percentage premium currently paid on fees for Consultation, Visit, Counselling, and Complete Examination services, when provided in-person or by Telehealth in a community-based office in an eligible geographical location. Pre-2022 the British Columbia BCP pays an additional 5% of eligible services for those in the City of Vancouver (up to $60 per day), 4% in Metro Vancouver and Victoria (up to $48 per day), and 3% in all other communities (up to $36 per day).*
>
> *The 2022 British Columbia Physician Services Agreement allows for more than 100% increase in the BCP: Annual funding for the Business Cost Premium will be increased by:*
> *(A) $40 million to $75.7 million per year for Fiscal Year 2023/24; and*
> *(B) a further $9 million to $84.7 million per year for Fiscal Year 2024/25 and subsequent Fiscal Years.*

Alberta Business Cost Program

The Alberta Business Cost Program (BCP) supports practices where increased business costs are having an impact on stability and attractiveness, including family practice and other groups in like circumstances.

The Alberta BCP is designed to be available across the province. All physicians who provide visit services in an office-based setting are eligible to receive payments through a fee modifier of $3.59 on select office visit and consultation codes up to a maximum of 50 payments per day per physician.

Manitoba Community-Based Practice Supplement
Manitoba has recently introduced a new community-based practice support supplement that will provide a payment per in-person patient encounter starting October 1, 2023. This new tariff is being introduced to recognize the escalating clinic costs that can be associated with in-person visits in a community setting. Community based practice supplement, paid at $3.50, may be claimed in addition to an office/ home visit where practice expenses are incurred. A maximum of fifty (50) claims may be claimed per physician in any twenty-four period.

815. The OMA proposes a new fee code to help ease physician overhead costs, set at $5, payable as an add-on for assessments and consultations provided in community practices.

K. TARGETED FUNDING FOR HEALTH HUMAN RESOURCES

I. Introduction

816. Physician resource challenges are widespread across Ontario, affecting many specialties and geographic areas. Some regions such as the North, and rural and remote areas endure chronic undersupply issues that have never been effectively addressed, despite many attempts, through policy and incentive interventions. Such efforts have been fragmented, reactive rather than proactive, and not designed according to a coherent provincial health workforce strategy. Some specialties such as family medicine have lost their appeal to incoming cohorts of trainees as viable and rewarding career options.

817. The Ontario population is increasing, aging, and experiencing a higher volume and complexity of health issues. The COVID pandemic exposed the many cracks in an unintegrated, fragmented system which does not effectively support its health care workforce or optimize patient access to high-quality health care close to home. There are shortages in almost every specialty and every region of Ontario. As a result, various initiatives focusing on retention, recruitment, and return of physicians to the workforce are urgently needed.

818. The OHRC (the OMA's human resources committee) has examined issues and engaged with multiple sectors and groups, including but not limited to the following areas/specialties of particular challenge:

- Comprehensive Family Medicine
- Northern, rural, and remote geographies
- Psychiatry and Mental Health
- Anesthesia
- Rheumatology
- Obstetrics and Gynecology
- Small specialties with retention challenges e.g. Radiation Oncology

- Academic clinical faculty in order to support a sustainable medical education

- Physicians practicing in certain “urban pockets” (e.g. family medicine in certain areas of Toronto and burgeoning population areas like Mississauga and Brampton; internal medicine in Toronto-center).

819. The physician workforce has experienced significant shifts in recent years. For example, physicians have moved away from the practice of comprehensive office-based family medicine, away from practice in rural and remote regions, and toward more narrowed scopes of practice. Many have reduced their practices or retired early. Incentivizing physicians (not only those who have left the workforce) to the areas and types of practice most required by Ontario communities and patients will help to build a more stable and sustainable health system and should be a priority.

820. It also goes without saying that retaining physicians in the workforce is of critical importance. Attracting and retaining physicians at all career stages – from early-career physicians who are expected to provide decades of service to the health care system, through mid-career physicians whose clinical practices are stable and who are taking on leadership and administrative roles, to end-of-career physicians with large practices and a wealth of knowledge and experience – is a necessary intervention to stabilize the workforce and ensure the sustainability of the health system.

II. OMA HHR Proposal

a) Provincial Locum Program

821. A provincial locum program is foundational to a robust physician workforce, as locum support (temporary or substitute physician services) is critical to retention of non-locum clinicians in their practice settings.

822. Physicians may have various reasons for requesting locum coverage. Some common reasons for requiring locum support include vacation or personal leave, to be able to access in person continuing medical education, practice leave because of illness or injury, maternity/paternity leave, recruitment gaps, retirement or transitions in practice, workload management, practice expansion or relocation, and emergency or unexpected events. As well, in recent years, locums have been used not just to replace clinicians requiring temporary support for one of the above noted needs but also to fill contract vacancies and recruitment gaps.

823. A well-functioning provincial locum program has many benefits. It helps locum physicians maintain their skills (in particular, comprehensive family medicine, emergency medicine); it keeps physicians in the workforce, decreasing attrition and early retirement; it decreases burnout for physicians in practice; it increases physician autonomy and scheduling flexibility and facilitates backup systems and networking amongst physicians; it can leverage new licensure rules in Ontario; it appeals to physicians in the early, mid, and late stages of their careers; it can be used as a policy lever to secure coverage for underserved sectors, specialties and communities; it represents a sensible workforce management strategy; and it provides an opportunity to explore different career, community, and practice options, to connect with local physicians and/or establish new working relationships, referral networks, and mentoring or support network.

824. In consultation with the OMA Sections, Medical Interest Groups, Forums, Districts, Committees, Task Forces, as well as key external stakeholders, there are four main concerns identified with the current locum programs in Ontario: first, accessing the pool of available locums is complicated; second, the pool of available locums is often not sufficient to meet the needs; third, the locum opportunities are not available to all Ontario physicians; and fourth, the locum rates are not known, consistent across the province, or

in relativity to the compensation of physicians seeking locum support receive, which potentially raises equity concerns.

825. Based on a comprehensive review of the current locum programs offered in Ontario by the Health Force Ontario ("HFO"), an environmental scan of locum programs in other Canadian provinces and territories, recommended solutions from members and stakeholders, and feedback from the OMA's OHRC, the OMA proposes the following to address the identified concerns with the current locum program in Ontario, as follows.

i) OMA LOCUM PROPOSAL

1. *The objective of the new provincial locum program is to provide easy and equitable access to an adequate pool of qualified locum physicians to all physicians in Ontario at transparent, uniform, and fair locum rates, while at the same time, promoting the permanent recruitment of physicians.*

2. *This objective will be undertaken by a bilateral Locum Working Group, a subcommittee reporting to the bilateral PHRC which is charged to address the following.*

Easier Access

3. *The Parties will establish a new portal for locums in Ontario no later than April 1, 2025.*

4. *This portal will integrate:*
   a. *A single point of entry for the entire province;*
   b. *A simple intake form for the local physicians requiring locum services and locum physicians (e.g., name, specialty, location);*
   c. *A real-time, proactive, automated matching between local and locum physicians; and*
   d. *Any other access-enhancing features agreed to by the Parties (e.g., central credentialling support).*

Provincial Locum Pool

5. *The Parties commit to promoting the goal of maintaining an adequate pool of qualified locum physicians to complement the provincial physician workforce planning to meet the regional and local needs for physician services.*

6. *To this end,*

   a. *The Parties will identify regional and local needs for locum physicians on a regular basis.*

b. *The Parties will endeavor to maintain a locum pool sufficient to meet these needs.*

7. *The need for physician services will be informed using the Physician Resources Integrated Model (PRIME) and any supplemental information on regional and local gaps in physician services.*

8. *The Parties will develop and implement an on-going strategy informed by best practices to maintain an adequate pool of qualified locum physicians no later than April 1, 2025. This strategy will include the following key initiatives:*

    a. *Marketing Locum Opportunities, by regularly advertising on medical schools' postgraduate websites, through local and regional organizations, at conferences and CME events;*

    b. *Reducing Administrative Burden for locum physicians related to processing clinical, travel, accommodation and incidental expenses in applicable locum programs using a "concierge service" or a "travel agency" model;*

    c. *Establishing a Locum Support Program, integrated with the Skills Optimization proposal described below, to promote training and professional development by organizing conferences and workshops tailored for local and locum physicians conducted in appropriate communities; supporting local mentorship and support opportunities with experienced local physicians, co-deployment of locums, and real-time telephone support; and support establishment of a structured mechanism for locum networking and peer support.*

9. *To further advance the goal of maintaining an adequate pool of qualified locum physicians, the Parties also agree to:*

    a. *Fully subsidize the CMPA and CPSO fees for physicians in their late careers who commit to providing locum services as a major part of their practice.*
    b. *Continue to support and fast-track the implementation of Pan-Canadian licensure that will allow Canadian physicians licenced in other Canadian provinces to start practicing in Ontario.*

10. *The provincial locum program will be regularly monitored and evaluated by the bilateral Physician Human Resources Committee (PHRC) reporting to the Physician Services Committee.*

Eligibility and Entitlement

HFO Locum Programs

11. *The eligibility criteria and locum entitlement for the Rural Family Medicine Locum Program (RFMLP), Northern Specialists Locum Program (NSLP), and Emergency Department Locum Programs remain unchanged, except for the following:*

a. *Entitlement for RFMLP physicians will increase by one additional day for each year they remain practicing in a RFMLP eligible community, up to a maximum (30 days for physicians in FFS, CCM, FHG, FHN and FHO models and 50 days for RNPGA physicians), as a retention policy for currently practicing physicians in eligible communities.*

b. *The locum day entitlement for RNPGA physicians will be amended in the instance of a contract vacancy to ensure that the needs of the community can continue to be met in the absence of a filled contract position.*

Locum Contracts

12. *Physicians outside of the HFO Locum Programs will be entitled to 20 locum days per year to cover emergency leaves such as sick leave.*

Transparent, Uniform and Fair Locum Rates

HFO Locum Programs

13. *The Emergency Medicine Temporary Locum Program (EDLP) will be made permanent.*

14. *The subsidy for travel, accommodation, and incidental expenses will increase by 30 percent effective April 1, 2024 to reflect the impact of inflation since these subsidies were first established. Future automatic annual adjustments will be equivalent to the Ontario CPI growth until otherwise agreed between the parties.*

15. *The daily rurality premium in the RFMLP will extend to the NSLP.*

16. *The payment for clinical services in the RFMLP, NSLP and EDLP will increase by the global normative increase in the 2024 Agreement effective April 1, 2024.*

17. *The bilateral PHRC will review the compensation rates for clinical services and submit its recommendations to the PSC with the intended implementation date for the new rates as of April 1, 2025. This review will aim to set the locum rates at competitive (i.e., attractive to the locum physicians) but fair (i.e., comparable to the compensation rate of local physicians) levels.*

Locum Contracts

18. *For transparency, uniformity and fairness, the compensation rate for local and locum physician in the Locum Contracts will be set at the corresponding rates in the HFO Locum Programs. These rates will be published on the provincial locum program website and regularly updated.*

19. *Local physicians in the Locum Contracts will be eligible for a subsidy of $100 per day (for hospital-based practices) and $200 per day (for community-based practices), up to a maximum of 20 days per year. This subsidy intends to partially offset overhead and other costs borne by the local physicians.*

20. *To claim the locum subsidy, the local physician must submit the Q777 code. For documentation purposes, and to avoid double payments, the claim must be submitted using the local physician's billing number as the practicing physician, the locum's billing number as the referring physician, and the date when the locum services were provided as the service date. The local physicians must also include on the claim the hospital master number if locum services were provided in a hospital setting.*

21. *The locum subsidy is payable to any one physician providing clinical coverage for the local physician, including physicians from the same practice group as the local physician.*

b) Underserviced Area Programs

826. Underserviced area programs can play an important role in physician recruitment. Physician recruitment incentives for specialty practice in underserved areas can vary depending on multiple factors, including location, specialty demand, and local health care needs. However, to date, a comprehensive review of current and historic recruitment and retention initiatives has not been undertaken within Ontario.

i) *OMA UAP PROPOSAL*

1. *The PHRC will oversee the evaluation of the following underserviced area programs (UAP):*

    i. *Northern Rural Recruitment and Retention Initiative,*
    ii. *Northern Specialist Physician Outreach,*
    iii. *Psychiatry Outreach,*
    iv. *Visiting Specialist Program,*
    v. *Northern Physician Retention Initiative,*
    vi. *Rural Medicine Investment Program, and*
    vii. *Any other programs that the Parties agree to.*

2. *The evaluation of these programs will be completed by a bilateral UAP Working Group, a subcommittee reporting to the bilateral Physician Human Resources Committee (PHRC), by April 1, 2025.*

3. *The evaluation will be based on the best practice evaluation methodologies, such as balanced scorecards, return on investment analysis, key performance indicators, stakeholder feedback, benchmarking, and long-term impact assessment.*

4. *Based on this evaluation, the PHRC will submit its recommendations to the PSC for approval, with the intended implementation date of April 1, 2026. Among other things, the recommendations will be related to compensation, eligibility criteria, and enhancing program effectiveness.*

5. *The parties commit to funding of $10 million to fund changes to these programs by April 1, 2025.*

c) Continuing Medical Education

827. Continuing Medical Education is an essential part of medical practice for all physicians and requires support.

i) OMA CME PROPOSAL

The Parties agree to implement code Q555 ($25 for every 15 minutes for urban physicians and $40 for rural and Northern physicians) billable by all physicians for the purpose of completing and maintaining CME. This will be billable to a maximum of $3,000 for urban physicians and $4,800 per year for rural and Northern physicians.

d) Skill Optimization Programs

828. Optimizing the skills of the physician workforce - so that physicians can provide services when, where, and how they are needed - can support a flexible, responsive, and sustainable health system.

i) OMA PROPOSAL

1. *The Parties agree to allocate $10 million to fund a retraining and upskilling program.*

2. *The purpose of the program is to allow physicians to confidently transition to practice (e.g., return to practice, relocate to another location, transition to another area of care), to provide the kinds of care and services patients need, in the areas where they are needed.*

3. *The design of the program will be undertaken by a bilateral Retraining and Upskilling Working Group, a subcommittee reporting to the bilateral Physician Human Resources Working Group.*

4. *The PHRC will submit its proposal to the PSC by April 1, 2025, with the intended implementation date of April 1, 2026.*

e) Expert panel for Health Human Resources Issues and Solutions

829. Ontario needs an expert panel to assess physician workforce issues and promote solutions to identified issues. An expert panel will bring specialized knowledge, objective evaluation, and strategic recommendations to address health/physician human resource issues. Their involvement helps create a more informed and evidence-based approach to improving physician well-being and the health care system.

i) OMA EXPERT PANEL PROPOSAL

1. *The Parties agree to recognize the bilateral Physician Human Resource Working Group as an expert panel to be called the Physician Human Resources Committee responsible for reviewing physician resource issues in Ontario and providing recommended solutions to the bilateral Physician Services Committee (PSC).*

2. *The PHRC will consist of 5 members each from the OMA and MOH. Each Party is responsible for appointing its members and will endeavor to appoint members with relevant subject matter expertise and decision-making authority and experience.*

3. *Within two months of the ratification of this Agreement, the PHRC will present its work plan and new terms of reference for approval by the bilateral PSC.*

4. *The new terms of references will include the following:*

    a) *As a core objective to review health human resource issues in Ontario and provide recommended solutions to ensure an adequate physician workforce to meet current and future patient needs, address geographic and specialty imbalances, enhance health care quality and patient safety, promote continuity of care, facilitate effective succession planning, support optimal resource allocation, and optimize the composition and integration of the health workforce;*

    b) *To oversee the development and implementation of a new provincial locum program;*

    c) *To oversee the evaluation and revision of underserviced area programs; and*

    d) *To oversee the development and implementation of skill optimization programs for physicians.*

5. *To support fulfilling its new terms of references, the PHRC will establish a sub-committee for each paragraph (4b) to (4d).*

6. *The PHRC will meet monthly and report to the PSC quarterly.*

L. TARGETED RETENTION FUNDING

I. Background

830. The crisis in physician human resources is documented elsewhere in the OMA brief. This proposal is one of several proposals the OMA has identified as providing a partial solution to seeking to retain existing physicians in the province in their practice, and in recruiting new physicians to the province.

831. This type of recruitment and retention program has been implemented in Ontario as part of the 2007 Reassessment Agreement. This program, known as the Service Recognition Payment, made payments to eligible physicians each October of each year 2008 through 2012 based on their length of continuous practice in Ontario, with payment amounts ranging between $1,250 and $5,000 and service milestones at from 5 to 30 years of practice, and every 3 years thereafter.

832. Retention incentives are also prevalent in other Canadian provinces.

833. In Newfoundland and Labrador, the retention bonuses are paid based on geographical location and years of service in practice and range between $5,000 and $42,000. Physicians in PEI who have been in practice as of December of each year are eligible for annual retention incentives that range from $1,800 to $2,600, depending on the number of eligible physicians.

834. In Nova Scotia, there are a variety of rural recruitment and retention initiatives and in addition, a government committee to provide a new physician retirement fund modeled on the BC pension fund. New Brunswick offers recruitment incentives to eligible physicians, for both rural and urban areas, with a 4-year return of service agreement of $100K in rural areas and a 2-year ROS in urban areas for $50K.

835. Manitoba administers the Physician Retention Fund ($11.27 million), where physicians vest a share of the fund for each year of service and the value of the share

increases with years of service. Redemption of shares occurs on a rolling basis once the physician achieves five consecutive years of services. Share values range from $3,000 per year for the first five years of practice, to $6,000 per year for years 26 to 30.

836. In Saskatchewan, the Specialist Recruitment Incentive Program provides specialists with a grant of $30,000 if they establish a practice in Saskatchewan, with a 3-year return of service agreement. Saskatchewan also has Retention Fund designed to encourage the long-term retention of physicians. The retention benefit ranges from $3,500 per year for less than 9 years of continuous practice in the province to $7,000 per year for 20+ years.

837. Alberta also had the Retention Benefit Program of $45 million which was, unfortunately, eliminated under the terms of the second amending agreement. In BC, there is a contributory professional retirement savings plan that is scaled based on the years of service in BC. Northwest Territories also provides retention bonuses ranging between $13K and $52K per year, depending on the specialty and location of practice, paid after each complete year of service.

838. Lastly, Yukon has “Attach and Attract” program that has replaced the previous Recruitment and Retention Program.

II. OMA PROPOSAL

839. On April 1st in each year of this Agreement, active physicians who practiced in Ontario in the previous fiscal year and earned at least $120,000 in clinical payments will receive a retention bonus of $6,000. This amount will be prorated for physicians earning less than $120,000, and physicians who started practicing in Ontario in the previous fiscal year any time after April 1st of that year. At the physician’s option, the retention bonus will be payable as a contribution to the physicians’ Registered Retirement Saving Plan (“RRSP”) or any other eligible retirement funds, as agreed to by the Parties.

M. TARGETED FUNDING FOR PHYSICIAN EXTENDERS

I. Delegation Billing

a) Background

840. Interprofessional care utilizing physician extenders aligns with the priorities for access to care, decreased wait lists and improved evidence-based clinical care. However, the OHIP Schedule language, last revised in 2003, does not recognize the current standard of care and interprofessional practice models, and needs to be revised. Absent the OHIP Schedule revision, the supervisory model of care will not be sustainable, which in turn will adversely impact access to care.

841. For example, physician extenders, such as anesthesia assistants (“AAs”), nurse practitioners (“NPs”) and physician assistants (“PAs"), are well positioned with the skills to excel in team-based models of care and have the expertise to deliver a high-quality and safe clinical experience to patients under the supervision of physicians. By establishing collaborative, interprofessional care models in hospital and community settings, physician extenders can make a significant contribution to Ontario health care settings.

842. The shortage of anesthesiologists in Ontario is causing cancellations of surgeries and delaying treatment. The surgical backlog in Ontario is over 250,000 patients which is a substantial increase over the 40,000 patients prior to COVID-19. The Anesthesia Care Team model which was established in Ontario in 2007 helped address the shortage of anesthesiologists at that time. The number of Anesthesia Care Teams was limited, as was their scope of practice. The present proposal is to expand the potential of this physician extender group to help improve access to surgery.

843. Physician extenders can also help improve patient flow by taking on administrative work, such as patient care documentation, EMR documentation, discharge summaries, dictations, consult requests, reviewing and actioning patient lab results, completion of forms and patient education/health promotion. Current funding system is a barrier, which can be addressed by redefining delegation in the OHIP Schedule to include assessments and allow the supervising physician to bill the applicable assessment fee.

844. Interprofessional care utilizing physician extenders also aligns with the priorities for improving access to care, decreasing wait lists and improving evidence-based clinical care. However, the OHIP Schedule language, last revised in 2003, does not recognize the current standard of care and interprofessional practice models, and needs to be revised. Given the fact that physicians are presently prohibited from submitting claims for remuneration despite being responsible and liable for the activities of physician extenders, these supervisory models of care are limited and not achieving their potential benefits. Absent the OHIP Schedule revision, the supervisory model of care will not be sustainable, which in turn will adversely impact access to care.

845. Some of the key parts of the OHIP Schedule that need revision include providing clarifications (e.g., definition of a delegated procedure is ambiguous) and revisions to reflect the current standard of care and practice models (e.g., the OHIP Schedule precludes delegation when the delegate is not an employee of the physician; the OHIP Schedule defines limited circumstances that do not require physician presence, but in modern practice, physician extenders work along physicians, not without them).

b) OMA Proposal

The Parties agree to revise the OHIP Schedule as follows:

a. *Redefine delegation to include assessments where the physician has reviewed all aspects of the assessments including, as clinically appropriate, examination of the patient;*
b. *Provide that the service supervised by the physician is insurable under OHIP at the full OHIP Schedule rate where the physician is responsible in whole or in part for the compensation of the physician extender;*
c. *Provide that the service is insured regardless of the location where the service is provided (e.g., hospital, clinic);*
d. *In situations where the physicians are not responsible at all for the compensation of the extender, a supervision rate be billable at 75% of the OHIP Schedule's rate;*
e. *Services provided by physician extenders working autonomously that do not require supervision of the physician are not billable by the physician; and*

f. Explicitly provide for the expansion of anesthesia care teams.

II. Physician Extenders in Emergency Departments

a) Background

846. Access to care is limited by the physician resources available in many emergency departments. Ontario's patients need existing emergency physicians to remain energized and able to work to their fullest capacity. Emergency physicians are best utilized spending time at the bedside taking a history, examining the patient, managing emergencies, and providing discharge instructions.

847. At present, physicians spend a significant amount of time doing other tasks which could be delegated to a physician extender, such as searching past medical history in the EMR, copying out medication lists, moving patients into rooms and gowns and of charting within the EMR.

848. Other examples of ED physician extenders include; (a) physician assistants, who can help with complicated histories and even management of some patients, (b) navigators, who optimize the physician's time by moving patients, and obtain results and supplies and (c) scribes, who help with charting and time spent inside an EMR.

849. Every work environment is different and EDs likely have different extenders available in the community and different needs within their departments. Emergency physicians find the gridlock of overcrowded emergency departments, the checking of EMRs and the volumes of patients to be overwhelming, and this leads to significant loss in job satisfaction, burnout, and attrition. The use of physician extenders could alleviate some of these concerns and thereby improve the access and functioning of EDs generally.

b) OMA Proposal

850. The Parties agree to establish an Emergency Departments Physician Extenders ("EDPE") fund.

1. *EDPE will be available to both fee-for-service and EDAFA physicians for the exclusive purpose to hire physician extenders (scribes, navigators, and physician assistants).*
2. *For each 2,500 emergency department visits per year, each physician group is eligible for $30,000 in physician extender funding, with no more than $50,000 per physician in the group.*
3. *At the start of each fiscal year, physician groups will identify their request for hiring physician extenders to the MOH and receive the requested funding.*
4. *At the end of each fiscal year, physician groups will provide documentation to the MOH on the number and type of extenders hired, their total hours of work, and the compensation reimbursed over the year. Any unused funding will be carried forward to fund future requests.*

N. TARGETED FUNDING FOR RESTRUCTURING OF CMPA SUPPORT TO REFLECT UPDATED CMPA PHYSICIAN RISK CATEGORIES

851. Support for medical liability protection has been a critical component of agreements between the OMA and the Ministry for decades. It is in the public interest and the functioning of our publicly funded health care system for physicians to have long term cost certainty for their medical liability protection.

852. The amount of government support for Canadian Medical Protective Association ("CMPA") fees were initially set in 1985 based on the then prevailing medico-legal risks and based on risk categories for each type of work and the physician contribution or rate for each risk category. At the time, physician rates were set at a fixed amount, and any differences between the total CMPA fee and the physician rates resulting from fluctuations in medico-legal risks over time have been reimbursed by the government.

853. The 2012 Physician Services Agreement established a revised agreement between the OMA and Ministry relating to Ministry support for CMPA fees, as well as addressing the amount of the physician contribution to CMPA fees.

854. Under this agreement (Schedule H of the 2012 PSA), the government agreed to reimburse each specialty or group of physicians for the cost of CMPA, with the agreed physician portion increasing by 2.1% on an annual basis.

855. This Agreement has been continued since 2014, including under the most recent 2021-24 Physician Services Agreement.

856. The OMA understands that, while it has proposed to continue this arrangement (with the modifications described below) for the 2024-28 and 2028-32 PSA, the Ministry has agreed to continue the current reimbursement arrangement for the 2024-28 PSA, including agreeing (as under the 2021-24 PSA) that the CMPA agreement will remain in full force and effect and will not be altered, deleted or added to without agreement of the parties and unless changed as a result of the negotiation, mediation or arbitration of the renewal PSA.

857. However, the OMA also proposes that the physician contribution for each type of work be updated to reflect the most current medico-legal risks as assessed by the CMPA, and that the physician's contribution for each type of work be fixed for the term of the PSA agreement.

858. The physician rates for each risk category remained constant until the 2012 Physician Services Agreement. Under the 2012 agreement, the parties agreed that, effective January 1, 2014, the physician rates for all types of work would be the then current rates physicians were paying, plus either $200 or 22% of the amount physicians were currently paying (whichever was larger), with the exception of interns, residents, and clinical fellows which remained at the same rate over the entire period. Effective January 1, 2015 through December 31, 2023, the new rates were to be increased by 2.1% per year (the historical average of CPI over the previous 10 years).

859. The actual fees set by CMPA itself are established based on the actual medical legal experience of the specialty or type of work, which may well change over time. As the cost of protection increases or decreases within a specific specialty, the type of work category is placed in one of 7 different risk groups. An increase in fees could be a result of an adjustment within the risk category or a change in the risk category to which the type of work is assigned.

860. As a result, while the physician contribution rates set in the 2012 agreement were based on earlier rates that reflected the medico-legal risks at an earlier time, medico-legal risks have changed since that time. For example, the medico-legal experience for Anaesthetists dropped significantly as a result of numerous safety measures implemented in the specialty. This resulted in a shift in risk category and a reduction in fees. Conversely, Orthopedic Surgeons saw an increase in their medico-legal risk which resulted in a shift from risk group 5 to risk group 6.

861. For ease of reference, the definition of the CMPA type of work is set out immediately below, with corresponding CMPA fee codes by region (including Ontario):

CMPA Empowering better healthcare

2024 CMPA MEMBERSHIP FEES

CMPA membership fees are based on your region and type of work (TOW).

To find your membership fee:

1. Select the TOW code that most accurately reflects all your professional responsibilities in the **Type of work (TOW) codes** table.
2. Locate your TOW code and fee region in the **2024 Fees by type of work and region table**.
3. If you have more than one TOW code and/or work in more than one fee region, please contact the CMPA for assistance with your selection.

TYPE OF WORK (TOW) CODES

In general, all practising TOW codes include the activities appropriate in **administrative medicine**, **teaching in Canada**, and **assistance at surgery**.

Family medicine or general practice	TOW
All family medicine or general practice codes include work in: • private offices • home care • walk-in/urgent care clinics • CLSC • hospitals or wards • nursing homes • chronic/long-term care facilities • If your work is primarily in physical medicine and rehabilitation, choose code 27. • If your work is primarily in geriatrics or palliative medicine, choose code 29. • If your work is restricted to occupational medicine, choose code 51. • If your work is restricted to minor cosmetic procedures, choose code 37.	
Family medicine, excluding anesthesia, obstetrics (labour and delivery), shifts in the emergency department, and surgery	**35**
Primary professional work in family medicine, including shifts in the emergency department • If your work is primarily in the emergency department, choose code 82.	**73**
Family medicine, including obstetrics (labour and delivery), anesthesia, surgery, and shifts in the emergency department	**78**
Family medicine, including anesthesia, surgery, and shifts in the emergency department	**79**

Postgraduate training	TOW
Residents and fellows without moonlighting—includes electives anywhere in Canada Residents and fellows registered in a postgraduate medical education program, international medical graduates registered in a program to obtain a licence for independent practice, and fellows and physicians pursuing a structured university-affiliated program. • Includes extra resident shifts but will not include CMPA assistance with medico-legal difficulties arising from independent practice of medicine outside the program.	**12**
Residents and fellows with moonlighting—includes electives anywhere in Canada Extracurricular (outside of a postgraduate training program) practice of medicine by residents and fellows registered in a full-time postgraduate medical education program. • Generally includes eligibility for CMPA assistance with medico-legal difficulties arising from independent practice of medicine outside of the program whether remunerated or not. • Residents and fellows who moonlight must hold licensure or registration acceptable to the regulatory authority (College) in the jurisdiction where the moonlighting takes place. • Residents and fellows who limit their clinical activities to moonlighting (e.g., locum) for more than 14 consecutive days must change to a practising physician code.	**14**

Work Abroad	TOW
Humanitarian work, teaching, or research abroad • Excludes the U.S., all U.S. territories, and all other countries where the U.S. legal system is applied. • There is a minimum period of one month and a maximum period of 12 months. • Members must confirm eligibility for assistance with the CMPA prior to leaving Canada.	**8**

Specialities	TOW
Administrative medicine (medical executive or advisor)—no prescriptions, no clinical or patient contact • Generally includes eligibility for CMPA assistance where medical input is used but will generally not include eligibility for CMPA assistance in matters related to non-medical acts performed in administrative roles, such as human resource matters or contractual issues.	**20**
Anesthesiology	**90**

Specialities *(continued)*	TOW
Biochemistry, medical	**24**
Cardiology	**70**
Clinical associates and hospitalists on a medical or surgical service • Includes assistance at surgery, pre/postoperative care. • Must not include CCU, ICU, NICU work, or emergency department shifts or consultation as part of specialist services. • Must not include labour and delivery, independent surgical practice, or fracture care. • *This code is not appropriate for specialists or family physicians who also have a general practice or work at a walk-in family-practice clinic.* • *This code is not appropriate for residents and fellows.*	**31**
Clinical immunology and allergy	**42**
Critical or intensive care medicine	**53**
Dermatology	**44**
Diagnostic radiology	**45**
Developmental pediatrics	**30**
Emergency medicine	**82**
Endocrinology and metabolism	**46**
Gastroenterology	**47**
Genetics, medical or genomics	**48**
Geriatrics and palliative medicine	**29**
Gynecology and obstetrics—without labour, delivery, or surgery, and restricted to office practice Includes infertility treatments.	**39**
Hematology	**50**
Infectious diseases	**52**
Internal medicine and its subspecialties—not elsewhere noted If your primary work is a subspecialty, choose the code of your subspecialty.	**54**
Microbiology, medical	**25**
Neonatal-perinatal medicine	**66**
Nephrology	**55**
Neurology	**56**
Nuclear medicine	**58**
Obstetrics—with or without gynecology	**93**
Obstetrics and gynecology—without labour, delivery, or surgery, and restricted to office practice Includes infertility treatments.	**39**
Occupational medicine	**51**
Oncology, medical	**59**
Oncology, radiation	**65**
Pain medicine—without general or spinal anesthesia	**38**
Palliative medicine and geriatrics	**29**
Pathology, anatomical or general	**21**
Pathology, hematological	**23**
Pathology, neuropathology	**26**
Pediatrics • If your work is primarily in emergency medicine, choose code 82. • If your work is primarily in developmental pediatrics, choose code 30.	**61**
Physical medicine and rehabilitation	**27**
Psychiatry and addiction medicine Includes shifts in the emergency department of a psychiatric hospital.	**36**
Public health and preventive medicine (community medicine)	**28**
Respirology	**62**
Rheumatology	**63**
Sport and exercise medicine	**64**
Teaching in Canada • Exclusive to members who **only** maintain a clinical teaching role within Canada. • You **must not** be in practice, make clinical decisions, write prescriptions, or undertake medical administrative work. • You may have contact with patients **only** for the purpose of clinical teaching, but without involvement in patient care.	**7**

Surgery	
Assistance at surgery—no other professional work and no prescriptions except for post-operative orders • Includes postoperative orders as part of surgical assistance duties only. • If your work is on the ward, choose code 31.	**33**
Cardiac surgery	**91**
General surgery	**83**
Gynecologic surgery—without labour and delivery If your work is restricted to office gynecology or obstetrics, choose code 39.	**84**
Neurosurgery	**92**
Ophthalmology	**60**
Orthopedic surgery	**94**
Otolaryngology (head and neck surgery–ear, nose, and throat) Includes cosmetic procedures restricted to the head and the neck.	**77**
Pediatric surgery	**85**
Plastic surgery	**86**
Surgical consultations and office surgical practice • Appropriate for physicians whose practice is restricted to minor cosmetic procedures that are consistent with their specialty training and that they can perform in an office setting under local anesthetic. • If your work is restricted to office gynecology or obstetrics, choose code 39.	**37**
Thoracic surgery	**87**
Urology	**88**
Vascular surgery	**89**

2024 FEES BY TYPE OF WORK AND REGION

Type of work codes	Québec		Ontario		British Columbia and Alberta		Saskatchewan, Manitoba, Atlantic, and the Territories	
	Incl. 9% applicable Québec tax							
	Annual fee $	Monthly pre-authorized debits $	Annual fee $	Monthly pre-authorized debits $	Annual fee $	Monthly pre-authorized debits $	Annual fee $	Monthly pre-authorized debits $
07	104.64	8.72	1,284.00	107.00	1,152.00	96.00	240.00	20.00
08	104.64	8.72	1,284.00	107.00	1,152.00	96.00	240.00	20.00
12	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
14	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
20	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
21	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
23	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
24	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
25	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
26	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
27	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
28	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
29	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
30	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
31	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
33	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
35	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
36	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
37	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
38	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
39	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
42	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
44	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
45	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
46	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
47	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
48	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
50	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
51	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
52	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
53	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
54	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00

2024 FEES BY TYPE OF WORK AND REGION (continued)

Type of work codes	Québec		Ontario		British Columbia and Alberta		Saskatchewan, Manitoba, Atlantic, and the Territories	
	Incl. 9% applicable Québec tax							
	Annual fee $	Monthly pre-authorized debits $	Annual fee $	Monthly pre-authorized debits $	Annual fee $	Monthly pre-authorized debits $	Annual fee $	Monthly pre-authorized debits $
55	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
56	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
58	104.64	8.72	2,904.00	242.00	2,232.00	186.00	240.00	20.00
59	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
60	353.16	29.43	11,340.00	945.00	6,984.00	582.00	900.00	75.00
61	353.16	29.43	11,340.00	945.00	6,984.00	582.00	900.00	75.00
62	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
63	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
64	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
65	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
66	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
70	235.44	19.62	7,596.00	633.00	4,788.00	399.00	612.00	51.00
73	156.96	13.08	4,488.00	374.00	3,420.00	285.00	408.00	34.00
77	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
78	353.16	29.43	11,340.00	945.00	6,984.00	582.00	900.00	75.00
79	353.16	29.43	11,340.00	945.00	6,984.00	582.00	900.00	75.00
82	353.16	29.43	11,340.00	945.00	6,984.00	582.00	900.00	75.00
83	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
84	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
85	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
86	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
87	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
88	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
89	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
90	353.16	29.43	11,340.00	945.00	6,984.00	582.00	900.00	75.00
91	470.88	39.24	16,368.00	1,364.00	11,556.00	963.00	1,632.00	136.00
92	640.92	53.41	32,676.00	2,723.00	21,012.00	1,751.00	2,964.00	247.00
93	1,281.84	106.82	58,548.00	4,879.00	38,076.00	3,173.00	5,496.00	458.00
94	640.92	53.41	32,676.00	2,723.00	21,012.00	1,751.00	2,964.00	247.00

862. Under the current CMPA reimbursement structure, the physician contribution rate for the type of work 90 (Anesthesia) and 92 (Neurosurgery) is identical at $7,361, even though the total CMPA rate is quite different: $11,340 for Anesthesia and $32,676 for Neurosurgery.

863. The OMA proposes that the physician contribution for each type of work be reset to reflect the most current medico-legal risks as assessed by the CMPA for that type of work. The complete table with the current and proposed contribution rates is set out below:

Type of Work	Description of Type of Work Code	FULL 2024 CMPA Fee	Physician Contribution		Difference
			Current Agreement	OMA Proposal	
12/14	Residents and Fellows - With moonlighting/restricted registration - Includes out-of-province electives	$2,904	$300	$300	$0
20	Administrative medicine - Medical executive/advisor/expert	$2,904	$740	$740	$0
23	Pathology – Hematological	$2,904	$740	$740	$0
24	Biochemistry – Medical	$2,904	$740	$740	$0
25	Microbiology – Medical	$2,904	$740	$740	$0
26	Pathology – Neuropathology	$2,904	$740	$740	$0
27	Physical medicine and rehabilitation	$2,904	$740	$740	$0
28	Public Health and Preventative medicine (Community medicine)	$2,904	$740	$740	$0
33	Assistance at surgery	$2,904	$1,047	$740	-$306
46	Endocrinology and metabolism	$2,904	$1,353	$740	-$613
48	Genetics – Medical	$2,904	$1,353	$740	-$613
51	Occupational medicine	$2,904	$1,353	$740	-$613
52	Infectious diseases	$2,904	$1,353	$740	-$613
58	Nuclear medicine	$2,904	$1,353	$740	-$613
31	Clinical associates and hospitalists on a medical or surgical service	$4,488	$1,047	$1,047	$0
35	Family medicine or General practice - Excluding anesthesia, obstetrics (labour and delivery), shifts in the emergency department, and surgery	$4,488	$1,047	$1,047	$0
36	Psychiatry and addiction medicine	$4,488	$1,047	$1,047	$0
37	Surgical consultations/Office surgical practice	$4,488	$1,047	$1,047	$0
73	Family medicine or General practice - Primary professional work in family medicine including shifts in the emergency department	$4,488	$1,047	$1,047	$0
42	Clinical Immunology and Allergy	$4,488	$1,353	$1,047	-$306
44	Dermatology	$4,488	$1,353	$1,047	-$306
55	Nephrology	$4,488	$1,353	$1,047	-$306

59	Oncology – Medical	$4,488	$1,353	$1,047	-$306
62	Respirology	$4,488	$1,353	$1,047	-$306
63	Rheumatology	$4,488	$1,353	$1,047	-$306
64	Sport medicine	$4,488	$1,353	$1,047	-$306
65	Oncology - Radiation	$4,488	$1,353	$1,047	-$306

Type of Work	Description of Type of Work Code	FULL 2024 CMPA Fee	Physician Contribution		Difference
			Current Agreement	OMA Proposal	
21	Pathology - Anatomical or General	$7,596	$740	$1,353	$613
38	Pain medicine	$7,596	$1,353	$1,353	$0
39	Obstetrics/Gynecology	$7,596	$1,353	$1,353	$0
45	Diagnostic radiology	$7,596	$1,353	$1,353	$0
47	Gastroenterology	$7,596	$1,353	$1,353	$0
50	Hematology	$7,596	$1,353	$1,353	$0
53	Critical/Intensive care medicine	$7,596	$1,353	$1,353	$0
54	Internal medicine and its subspecialties - not elsewhere noted	$7,596	$1,353	$1,353	$0
66	Neonatal-perinatal medicine	$7,596	$1,353	$1,353	$0
70	Cardiology	$7,596	$2,251	$1,353	-$898
60	Ophthalmology	$11,340	$1,353	$1,802	$449
61	Pediatrics	$11,340	$1,353	$1,802	$449
78	Family medicine or General practice - Including obstetrics (labour and delivery), anesthesia, surgery, and shifts in the emergency department	$11,340	$1,802	$1,802	$0
79	Family medicine or General practice - Including anesthesia, surgery and shifts in the emergency department	$11,340	$1,802	$1,802	$0
82	Emergency medicine	$11,340	$2,251	$1,802	-$449
90	Anesthesiology	$11,340	$7,361	$1,802	-$5,559
56	Neurology	$16,368	$1,353	$2,500	$1,147

77	Otolaryngology (head and neck surgery)	$16,368	$2,251	$2,500	$249
83	General surgery	$16,368	$5,258	$2,500	-$2,758
84	Gynecologic surgery	$16,368	$5,258	$2,500	-$2,758
85	Pediatric surgery	$16,368	$5,258	$2,500	-$2,758
86	Plastic surgery	$16,368	$5,258	$2,500	-$2,758
87	Thoracic surgery	$16,368	$5,258	$2,500	-$2,758
88	Urology	$16,368	$5,258	$2,500	-$2,758
89	Vascular surgery	$16,368	$5,258	$2,500	-$2,758
91	Cardiac surgery	$16,368	$7,361	$2,500	-$4,861
92	Neurosurgery	$32,676	$7,361	$7,361	$0
94	Orthopedic surgery	$32,676	$7,361	$7,361	$0
93	Obstetrics	$58,548	$7,361	$7,361	$0

864. Thus, the OMA proposes that, with the exceptions below, all types of work that have the same total CMPA fee (which reflect most current actuarial risk factors) have the same physician contribution. For example, the type of work 61 (Pediatrics) and 79 (Family Medicine or General Practice, including anesthesia, surgery and shifts in the emergency department) would have the same physician contribution rate ($1,802) given that the total CMPA rate for these two categories is identical ($11,340).

865. In the OMA proposal, other than residents and fellows, there are 6 risk categories, with types of work in each category having the same total CMPA fee.

866. The exception to this is type of work 93 (Obstetrics), the type of work with the highest CMPA fee, which is grouped together with the two types of work (92-Neurosurgery and 94-Orthopedic Surgery) with the second highest CMPA total fee.

867. The seventh risk category is residents and fellows, whose contribution would continue to be fixed at $300.

868. Finally, the OMA proposes that, should a new type of work that does not currently exist be introduced by CMPA during the term of the CMPA agreement, the physician contribution would be set at the same physician contribution level as other most similar types of work. Any dispute with respect to the categorization of this new type of work will

be referred to William Kaplan for a final and binding determination throughout the term of the CMPA agreement, whether or not Mr. Kaplan continues as the mediator/arbitrator for the 2028-2032 PSA negotiations.

O. BENEFITS

I. Physician Health Benefit Program ("PHBP")

869. The 2004 Physician Services Framework Agreement and 2008 Physician Services Agreement provided for the creation of the Physician's Health Benefit Program ("PHBP"), effective January 1, 2008, which provides Ontario physicians with health insurance coverage (including critical illness, extended health care ("EHC") insurance and an optional health spending account).

870. Until the 2021-24 PSA, the Ministry had provided $25 million in funding for this program annually since it launched in January 2008, with no funding increases since inception, while program participation grew by 23% and costs increased by 152%.

871. Under the 2021-24 PSA, recognizing the growing cost of providing physicians with insured health benefits, and the growing need for such health benefits particularly during and coming out of the pandemic, the Ministry agreed to make modest improvements to funding of the PHBP, increasing annual funding to $28.5 million, effective April 1, 2022, and to $31 million effective April 1, 2023.

872. However, to account for increased number of participants, increased claim costs resulting from inflation and increased claims utilization, and in order to be able to continue to provide physicians with necessary and stable health insurance benefits, the OMA proposes to further increase the government contribution to the PHBP as follows:

- April 1, 2024 $38.0M
- April 1, 2025 $39.5M
- April 1, 2026 $42.0M
- April 1, 2027 $47.0M

873. This increased funding includes administration costs to the OMA equal to $846,900.

874. This increased government funding is supported by both year over year growth in physicians enrolled in the program (estimated to be 1.9%) but more importantly by the increased costs of providing the benefit under the program, as set out below.

Plan Year	Health Premium Increase	Health & CI Participant Premium Share [1]	Health Spending Account Cost [2]	Individual Participant Cost (in $ milions)
2020/21	15%	30%	$50	$18.2M
2021/22	17%	35%	$50	$20.4M
2022/23	12%	45%	$50	$26.5M
2023/24 [3]	20%	47.5%	$50	$33.5M
2024/25 [3]	14%	47.5%	$50	$40.0M
2025/26 [3]	14%	47.5%	$50	$45.0M
2026/27 [3]	14%	47.5%	$50	$51.1M
2027/28 [3]	14%	47.5%	$50	$57.4M

[1] Effective January 1st

[2] Annual Health Spending Account participant cost

[3] Projected for Plan Years 2023/24 and thereafter

2020/21	15%	30%	$50	$18.2M
2021/22	17%	35%	$50	$20.4M
2022/23	12%	45%	$50	$26.5M
2023/24 [3]	20%	47.5%	$50	$33.5M
2024/25 [3]	14%	47.5%	$50	$40.0M
2025/26 [3]	14%	47.5%	$50	$45.0M
2026/27 [3]	14%	47.5%	$50	$51.1M
2027/28 [3]	14%	47.5%	$50	$57.4M

[1] Effective January 1st

[2] Annual Health Spending Account participant cost

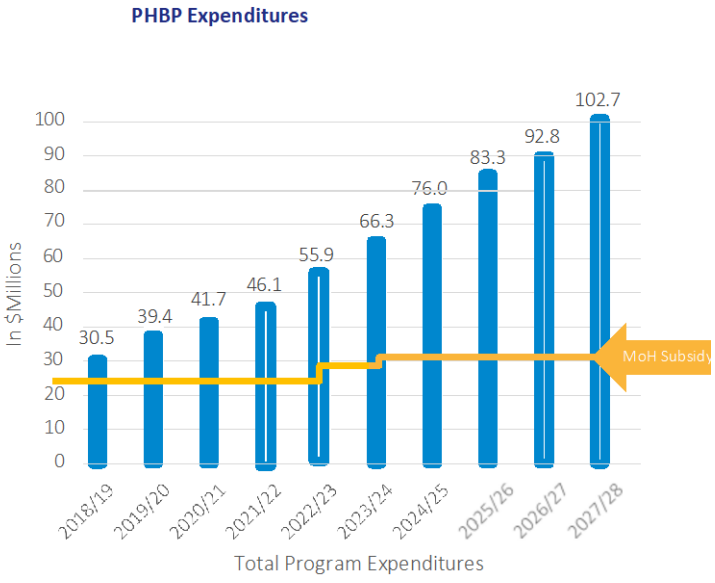
[3] Projected for Plan Years 2023/24 and thereafter:

875. Moreover, without the proposed additional Ministry funding support, a $40.3 million deficit is projected by 2027/2028. In particular, with increasing participation and inflation, if no change is made to the current funding ($31 million from the Ministry and 47.5% cost-sharing by physicians effective January 1, 2024) the program will be in a projected deficit of $40.3 million dollars by the 2027/28 program year.

876. Indeed, at the current Ministry funding level of $31 million dollars, by 2028, the government support will only offset 30% of total plan expenditures, as opposed to 82% in 2018, as illustrated below:

MoH Physician Health Benefit Program Subsidy

- Subsidy increased to $28.5M in 2023 and to $31M in 2024
- Participation YoY growth = 1.9% (to 18,670 physicians in 2028)
- Percentage of physicians enrolled in the program remains stable at ~53%
- At the current funding level, by 2028, the subsidy will offset 30% of total plan expenditures, vs 82% for 2018



II. Pregnancy and Parental Leave Benefit Program ("PPLBP")

877. The Pregnancy and Parental Leave Benefit Program ("PPLBP") is vital to any physician parent welcoming a child into their home.

878. However, the current PPLBP weekly maximum reimbursement amount and the current duration of payments is increasingly out of line with the pregnancy and parental leave benefit provided by other provinces, both in terms of the maximum quantum of the benefit, and the length of the partially paid leave.

Summary Table	**Benefit Amount/week**	**Weeks Available**
Province		
FMSQ	$2,400	12
NS	$2,000	26
MB	$2,000	20
Sask	$2,000	20
FMOQ	$1,809	12
NFLD	$1,500	17
B.C	$1,300	17
Ont.	**$1,300**	**17**
PEI	$1,200	17
AB	$1,074	17
NB	$1,000	17

879. There is no basis for support for Ontario physician parents not being at or near the highest levels in Canada. As a result, the OMA proposes the improvements set out below, and estimates that the cost of these improvements would be $23.5 million.

880. The improved benefit amount and duration would be effective for any leave that commenced as of April 1, 2024.

Proposal:

1. *Increase weekly maximum:*

The OMA proposes to increase the benefit payment maximum of $1,300 per week to $2,000 per week. This would bring Ontario the same level as Nova Scotia, Manitoba, and Saskatchewan.

2. Length of Leave:

The OMA proposes that the maximum length of leave increase from 17 to 26 weeks of combined pregnancy and parental leave for all parents, i.e., those giving birth, including stillbirth, or otherwise becoming a parent (including adoption, surrogates). This would place Ontario equal to Nova Scotia.

3. Exceptions:

All other current exceptions and parameters (e.g., initiation of leave, reimbursement rate) in the pregnancy and parental leave benefit program would continue, as reflected in the Ministry's Pregnancy and Parental Leave Benefit Program Guidelines, which can be found here: https://www.ontario.ca/page/pregnancy-and-parental-leave-ontario-physicians

P. TARGETED FUNDING SUPPORT FOR PHYSICIAN RETIREMENT SAVINGS

881. It is widely recognized that the most efficient way to provide for retirement income is through a pension, which, among other things, takes advantage of tax incentives provided for retirement savings. Providing pension support for Ontario physicians would also support recruitment and retention of physicians at a time of growing shortages, as well as facilitating physician workforce planning.

882. However, at the current time, there is no pension system for Ontario's self-employed physicians. The overwhelming majority of Ontario physicians are required to self-fund 100% of their own retirement savings (unless they are employees covered by a pension plan, e.g., participating in HOOPP, where there are also employer contributions).

883. Recent Federal Government proposed changes to the capital gains inclusion rate would negatively impact many physicians' retirement planning, making financial support for physicians and a physicians' retirement savings plan even more necessary.

884. Ontario physicians typically have had two primary options for retirement savings: individual retirement planning vehicles and the Advantage Retirement Plan developed by OMA Insurance.

885. However, recent legislative and pension industry innovation makes a defined benefit plan option or model available to eligible OMA members. Preliminary assessments suggest this model would provide a comparatively better retirement savings product than existing options for most eligible OMA members.

886. As a result, the OMA proposes that the Ministry provide retirement and pension financial support to Ontario physicians. The OMA's proposal constitutes a modest first step in providing targeted compensation to physicians to facilitate and promote the advantages of secure retirement savings.

887. The OMA's proposal has two components. The first related to providing immediate financial support for dedicated physician retirement savings, as follows:

1. *Dedicated Retirement Savings Funding Support (through a Contributory Professional Retirement Savings (CPRSP) account)*

    a. *Effective April 1, 2025 or earlier, Ministry of Health to provide a "retirement benefit" to physicians through a physician retirement benefit program.*

    b. *Under the program, physicians will be reimbursed for amounts paid by them into eligible retirement savings arrangements from an account established for that purpose, called a Contributory Professional Retirement Savings (CPRSP) account. Appropriate methodology for verifying the physician contributions will be established.*

    c. *OMA to be responsible for administering the reimbursement program, including the CPRSP account. Ministry funding will be required for the set up and ongoing administration of the program.*

d. Physicians will apply annually to the OMA for reimbursement of amounts contributed to retirement savings arrangements and provide proof of such contributions.

e. Physicians will be eligible for up to $10,000 reimbursement of permitted retirement savings per year from the CPRSP account, with any unused reimbursement to carry forward for up to one year.

f. Eligible retirement savings vehicles include, at the physician's option, any one or combination of the following: registered savings vehicles that are (a) individual RRSP accounts, (b) TFSA accounts, (c) Advantage group RRSP accounts, (d) any other registered retirement savings vehicle, or (e) a new defined benefit plan option to be developed in accordance with Part B below.

g. Every Physician who received at least $120,000 in payments from the Ministry of Health in the prior fiscal year will be eligible for a $10,000 reimbursement while physicians who received less than $120,000 will be eligible for a prorated reimbursement amount. For greater certainty, a physician is eligible for the full reimbursement amount if they receive $120,000 in aggregate from the Ministry of Health in any eligible year, or a lower reimbursement pro-rated to the aggregate amount received from the Ministry of Health.

h. Reimbursements to eligible members for 2025 to be made in advance of the RRSP deadlines with similar timeframe for subsequent years.

i. A joint OMA/Ministry of Health retirement program benefit committee is to be established to, among other things, determine the terms of OMA administration function; establish the funding obligations, timing and sequencing of payments from Ministry of Health to the CPRSP account; establish the basis upon which physicians are to provide information in order to receive reimbursement; resolve issues of benefit administration and dispute resolution. These terms will be included in a retirement benefit funding and administration agreement as a schedule to the Physician Services Agreement. If the parties cannot agree on these matters, they will be determined by the board of arbitration established to decide the 2024-2028 PSA.

888. The second aspect of the OMA's proposal is to develop an OMA Defined Benefit retirement savings plan option, which would be one of the eligible retirement savings arrangements under the CPRSP, as follows:

2. Development of OMA Defined Benefit Retirement Savings Plan Option

Through the creation of a joint OMA/Ministry retirement program benefit committee, the parties will also assess and work out the development of a defined benefit retirement savings plan option for eligible OMA members, which will be one of the eligible retirement savings arrangements under the CPRSP.

Key elements of a defined benefit retirement savings plan include:

a. Determining eligibility to participate through existing employer-employee relationship, including through a medical professional corporation.
b. Developing a simplified procedure to enable participation.
c. Establishing template process to enable participation.
d. Considering the need for additional financial advisory, tax or other services, if any, required to enable participation.
e. Establishing variable contribution rates.
f. Confirming the nature of guaranteed projected benefits in retirement (e.g., annuity from pension fund).
g. Ensuring the ability to buy past service (including transfer of RRSP/locked in savings).
h. Establishing and outlining the role of the OMA in administration.
i. Determination of and negotiating with "back end" administrator, being one of the major jointly sponsored pension plans operating in Ontario
j. Establishing an OMA pension administration committee or entity.
k. Entering into necessary contractual arrangements, including affinity/ administration agreements with back-end pension plans, standard pension service providers (actuarial, legal, consulting).

Q. TARGETED FUNDING FOR GOOD FAITH PAYMENT FOR PHYSICIAN SERVICES/ TIGHTENED TIMELINES FOR MANUAL REVIEW

I. Good Faith payment policy for addressing OHIP eligible but uninsured services and infant registration issues

a) Background

889. A "good faith" claims payment policy was in place in Ontario until March 1, 1998. This policy provided that where "the provider could not determine an eligibility problem by looking at the health card, claims were paid until such time as the provider had been notified by the Ministry via the provider's monthly RA" (Ref: June 2015 version of Registration for Ontario Health Insurance Coverage). Bulletin 4303 describes the end of these "Good Faith" payments. The discontinuation of this policy was apparently justified by the existence of three automated validation mechanisms made available to hospitals

in 1994. Since there were now ways to confirm the validity of a patient's health card number, it was argued that the "Good Faith" payment policy was no longer necessary.

890. The "Good Faith" payment policy also funded care provided by physicians to Ontario residents who were OHIP eligible but did not have valid health coverage.

891. In March 2020, in response to the COVID pandemic, the Ministry of Health established temporary payment mechanisms to facilitate hospital and physician payments for medically necessary services provided to patients who are not currently insured under OHIP or another provincial plan. These measures were discontinued on March 31, 2023.

892. While the COVID initiatives to fund physician services for uninsured persons were in place, it became apparent that many physicians in both hospital and community settings provide medically necessary services to Ontario residents who may not have OHIP insurance. For example, physicians in specialties such as addiction medicine may provide a significant portion of their services to marginalized and vulnerable patients who may not have valid health card numbers. The termination of the COVID Physicians and Hospitals Services for Uninsured Persons program has resulted in these physicians being unable to obtain payment for critical services provided to some of the most vulnerable Ontarians.

893. Some provinces such as BC have had Good Faith payment policies in place for decades, while others have recently moved to establish/re-establish their "Good Faith" payment policies (including Saskatchewan, Alberta and most recently Manitoba).

b) Specific challenges with payments for physician services provided to Newborns

894. There is an additional challenge to physicians obtaining payment for services provided to newborns which is not new and which the Ministry and the OMA have been working for years. Some of the measures taken included:

- Revisions to Pre-Assigned Health Numbers ("PAHN") registration process, reducing the amount of information required for successful registration;
- Education session for hospital staff about hospitals' roles and responsibilities in the PAHN process in situations where newborns do not survive; and
- Work with ServiceOntario to streamline the PAHN registration process.

895. Despite these processes, many hospital-based pediatricians continue to experience a high rate of rejections for services provided to newborns, as set out in the report "Challenges with the Infant Registration Program for Newborns in Ontario" prepared by Dr. Jane Healey, a Toronto pediatrician.[385]

896. The newborn registration process was not taken into account during the discontinuation of the "Good Faith" payment policy. To date, there is no way for physicians to validate the Pre-Assigned Health Number ("PAHN") issued to a newborn at birth by hospital staff. Any claims billed under the PAHN can be rejected 3 months later for reasons completely outside of a physician's control. For the past 25 years, physicians caring for newborns have had to deal with rejected newborn claims leading to a significant administrative burden in efforts to obtain updated health card numbers and lost income when this information cannot be obtained from the family.

897. Some provinces allow services provided to newborns to be claimed against a parent's health care number whereas others may allow claims for rejected services under temporary health care numbers to be submitted through Good Faith Payment Programs. In Manitoba, one of the main reasons for establishing a good faith policy was to allow for payments for newborns where the newborn registration process is incomplete.

898. The OMA estimates this would result in an additional $3.8 million being paid to physicians, although to be clear this is compensation that should have been provided in the first place.

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[385] Healey, Jane, "Challenges with the Infant Registration Program for Newborns in Ontario" prepared by Dr. Jane Healey, a Toronto pediatrician, TAB 226 BOD VOL 8.

c) OMA Good Faith Proposal

PROPOSAL

1. *Allow all claims made under the Pre-Assigned Health Number to be eligible for payment for a period of 3 months.*

2. *Restore the "Good Faith" payment policy or equivalent policy, on terms to be discussed and negotiated.*

3. *Ensure physicians are paid for medically necessary services provided in a hospital or a community where reasonable attempts to validate OHIP coverage have been made.*

4. *If the parties have any disputes regarding implementation of the above, these may be referred by either party to William Kaplan, acting as sole mediator/arbitrator, for final and binding determination.*

II. Manual Review

a) Background

899. Ontario physicians are experiencing significant adjudication delays and rejections, resulting in underpayment and a backlog of claims submission payments. Often, in order to receive payment, the physician is required to manually submit supporting documentation, even where not a requirement in the OHIP Schedule. Physicians from all different regions and practice areas have been affected, but there appears to be a significant number of physicians affected who are associated with surgical specialties.

900. In January 2020, the PSC established the Post-Payment Accountability Steering Committee to oversee the implementation of changes to the administration of OHIP payments and related processes. While not part of post-payment accountability, the MOH and the OMA have established the Claims Adjudication Sub-Committee ("CASC") as a permanent committee with the objectives of reviewing and making recommendations around:

- The claims submission process;
- The automated Medical Claims Payment System ("MCPS"), such as the OHIP system "Medical Rules" and error/explanatory codes; and
- The claims adjudication process, such as manual reviews and remittance advice inquiries ("RAIs").

901. CASC operated until early 2022 but was eventually put on pause for a number of reasons, including disagreement from both parties on joint communications to OMA Constituencies and members. This matter was raised at the Operational Working Group to provide guidance on how to move forward. CASC remains on pause at this time.

b) OMA Proposal

902. The OMA proposes to amend the CASC's terms of reference as outlined below:

Amended Claims Adjudication Sub Committee Terms of Reference

BACKGROUND

The Ministry of Health (MOH) and the Ontario Medical Association (OMA) agree to continue to make every reasonable effort to ensure a timely and consistent process for adjudication of all in-province OHIP physician claims for payment. To that end, the Parties have agreed to establish the MOH/OMA Claims Adjudication Sub-Committee (CASC).

MANDATE

The CASC will review specifically identified claims adjudication issues commonly encountered by multiple physicians and/or by the MOH in order to make recommendations to:

- *better explain/communicate the claims operational processes,*
- *improve the accuracy, efficiency and accountability of the operational claims processes,*
- *support consistency in the process for adjudication of claims.*
- *Improve transparency and understanding of the automated Medical Claims Payment System (MCPS) for physicians by,*
  - *i. reviewing, modifying and publishing the "OHIP computer rules" on the internet in an easy to read format.*
  - *ii. Review and update the explanatory and error codes currently posted on the internet.*
- *Implement ability to track claims under review on the Remittance Advice (RA) report,*
- *Establish 3 months deadline on MOH to respond to billing claims, similar to deadlines on physician claim submissions or payment is made in full,*
- *Establish an Ombudsman role to investigate physician complaints on delayed/declined payments,*
- *Establish new prior approval process, and*
- *Review all Independent Consideration agreements approved by the Ministry (current and future) and bring forth recommendations on at least an annual basis to the PPC.*

Common issues addressed by the CASC will typically fall within the following areas unless agreed to by the Parties:

1. *The claims submission process:*
   - *a. In-Province claims for payment*
   - *b. Reciprocal Medical Billing*

2. *The automated Medical Claims Payment System (MCPS)*
   - *a. Advance and automated payment process policies for FFS physicians, including pre-payment issues*
   - *b. Medical Claims Payment System rules (OHIP system "Medical Rules") for specific examples identified*

c. *Issues with error codes and/or explanatory codes*
d. *Mandatory claims data*

3. *The claims adjudication process*
   a. *Supporting documentation requested in order to review, adjust, pay, or deny a submitted claim*
   b. *Timeliness of payments and responses to RAIs*
   c. *Inquiries related to a claims payment decision*
   d. *Efficiencies in claims adjudication process (e.g., reducing administrative burden associated with rejected claims)*
   e. *Communication between physicians and Claims Services Branch*

Note: The CASC will not resolve individual physician complaints regarding payment processing. Physicians with one-off/singular billing questions or issues will be directed to contact the CSB Connects inquiry system for billing support and issue resolution.

Agenda items or other issues that are not found to be within scope of these ToR of the CASC will be re-directed to the appropriate forum where possible.

Where the CASC is unable to achieve consensus on a recommendation, the matter will be referred to the Physician Payment Committee (PPC).

CASC MEMBERSHIP

The CASC will consist of three members appointed by the OMA and three members appointed by the MOH. The OMA and the MOH will each appoint a Co-Chair from among its members. OMA and MOH program staff will support the CASC.

FREQUENCY OF MEETING

Meetings will be held monthly for the first six months with a focus on the priority items identified in the committee workplan, after which meetings will be quarterly. At the request of either co-chair, resolution of issues requiring immediate attention will be addressed through discussion between the Co-Chairs.

For efficiency, the CASC will also pursue identification and addressing of issues through email correspondence where possible.

PROCESS

The Parties will be responsible for the expenses related to their own representatives and staff. The Parties may temporarily substitute or permanently replace representatives without notice.

REPORTING

The CASC will report and make recommendations to the PPC. The CASC will provide status updates on a regular basis or as requested

Appendix I: Submissions identified as gender pay gap

Constituency	Type	FC	Description	Details
Emergency Medicine	New fee code	Gxxx	Emergency department pelvic exam with speculum	
General & Family Practice	New fee code	Exxx	Complexity Add on Fee to A007	Time based add on fee to A007 for service exceeding 20 minutes in duration
General & Family Practice	New fee code	Eyyy	Gender add-on premium to K131 and K132	
Obstetrics & Gynaecology	Value change and Revision	S760	Abdominal approach to vaginal vault prolapse - vaginal sacropexy	
Obstetrics & Gynaecology	Value change and Revision	S813	Female genital procedures - vagina - Repair - Abdominal approach to vaginal vault prolapse - repeat - vaginal sacropexy	
Obstetrics & Gynaecology	New fee code	Exxx	Anterior or posterior repair - when implant is used (Page V3)	Add-on fee to S716, S717, S718, S719, S723, S720, S721, S722, S812 when an implant is used for anterior or posterior repair.
Obstetrics & Gynaecology	New fee code	Zxxx	Transvaginal injection into pelvic floor muscle trigger point for chronic pain	
Obstetrics & Gynaecology	New fee code	Exxx	Transvaginal injection into pelvic floor muscle trigger point for chronic pain - eah additional injections (max 6)	
Obstetrics & Gynaecology	Value change	Multiple fee codes	Obstetrics And Gynaecology's Proposed Increases to Selected Fee Codes	* Fee value changes are recommended to address relativity, reduce the gender pay gap, and compensate for increased time and complexity
Reproductive Biology	Revision	S745	Oophorectomy - and/or oophorocystectomy	Requesting for the revision of the code for ovarian surgery to perform ovarian tissue transplantation, which requires similar training and skills to perform other ovarian/ pelvic surgeries.
Reproductive Biology	New fee code	Sxxx	Ovarian tissue processing and cryptopreservation	
Reproductive Biology	New fee code	Gxxx	Ovarian tissue thawing and preparation for transplantation	

Surgical Assistants	Value change	Multiple fee codes	Surgical assistant basic units relativity adjustments	* Increase from 6 to 8 base units for 7 codes where share of female surgical assistants is greater than 50%, to address the gender pay gap. FC: S738B, S758B, S745B, S757B, P018B, S816B, R110B
Surgical Assistants	Revision	S757B	Hysterectomy - with or without adnexa (unless otherwise specified) - abdominal - total or subtotal	Add S757 to table of services where a second assistant's services are payable and authorization is not required (GP 90).

Appendix II: Submissions identified as advances in medical innovation/technology

Constituency	Type	FC	Description	Details
Diagnostic Imaging	Value change	Multiple	Interventional Radiology codes, except those related to angioplasty and stenting.	IR is on the leading edge of innovation, with procedures becoming increasingly complex and time-consuming. Yet fees for IR procedures have not gone up (and in fact, have gone down substantially due to inflation as well as across-the-board cuts) for decades.
Gastroenterology	Value change	G350	Oesophageal Studies - oesophageal motility study(ies) with manometry	This test has evolved significantly over the years and now includes both pH testing and often impedance testing to look for non-acid reflux.
Gastroenterology	Value change	G351	Oesophageal Studies - oesophageal pH study for reflux, with installation of acid, with 24 hour monitoring	This test has evolved significantly over the years and now includes both pH testing and often impedance testing to look for non-acid reflux.
Allergy & Clinical Immunology	Revision	G190	Serial oral or parenteral provocation testing to a food, drug or other substance when the service is rendered in a hospital	Revise G190 to allow out of hospital claims for the following allergens: peanuts, tree nuts, milk and egg
Cardiac Surgery	New fee code	Jxxx	Direct epiaortic ultrasound of ascending aorta	
Cardiac Surgery	New fee code	Jxxx	Coronary doppler/transit flow time measurement	
Cardiac Surgery	New fee code	Zxxx	Cell salvage/washing for intraoperative blood loss	Implementation of auto transfusion technique using device for cell salvage and washing for blood conservation.
Cardiac Surgery	New fee code	Exxx	Minimally invasive	For all cardiac valve, vascular, structural or coronary procedure performed through minimally invasive, robotic, or beating heart approach.
Cardiac Surgery	Revision	G083	Haemodialysis - Continuous venovenous haemodialysis - initial and acute (for the first 3 services)	Allowed during cardiopulmonary bypass
Diagnostic Imaging	New fee code	J1xx	Ultrasound - Biophysical Profile (BPP)	On or after 28 weeks gestation, Ultrasound Evaluation of Fetal Biophysical Profile.

Constituency	Type	FC	Description	Details
Emergency Medicine	Revision	H100	Emergency department investigative ultrasound	* Increase limit from 2 to 3 services per patient/day and allow for updated list of medical indications.
Gastroenterology	New fee code	Exxx	Radiofrequency Ablation for Barrett's Esophagus	Only payable to gastroenterologists and general surgeons, who have been trained to perform this procedure and applicable medical diagnosis.
General Surgery	New fee code	Rxxx	Biopsy of suspected sarcoma, or resection of a complex bone or complex soft tissue tumour(s), per 15 minutes	This is the equivalent code to the orthopaedic sarcoma R226 fee code intended to be used by soft tissue sarcoma surgeons in exactly the same way
General Surgery (Member Group)	New fee code	Sxxx	Temporary abdominal closure with or without abdominal washout	
General Thoracic Surgery	New fee code	Rxxx	Open or VATS Drainage of pericardial effusion for Cardiac Tamponade	Drainage of pericardial effusion for unstable patients with documented clinical or Echocardiographic signs of tamponade.
Haematology & Medical Oncology	Revision	G390	Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation (maximum of 1 per induction phase or myeloablative therapy)	Revise to include "First infusion of bispecific antibodies (such as glofitamab) Chemotherapy for infusion of CART cells"
Haematology & Medical Oncology	New fee code	Gxxx	Systemic Therapy planning	
Infectious Diseases	New fee code	Axxx	Management of Fecal Microbiota Transplant	Clinicians would have to fulfil a consultation, plus perform fecal microbiota transplantation.
Neurology	Value change and Revision	G874	Botulinum toxin injection(s) for sialorrhea, (unilateral or bilateral)	Revise descriptor to: Botulinum toxin injection(s) for parasympathethic gland hyperfunction (e.g., sialorrhea, epiphora), (unilateral or bilateral)
Neurology	New fee code	Kxxx	Epilepsy Surgery Multidisciplinary Rounds	
Neurosurgery	New fee code	Nxxx	Endovascular Mechanical Thrombectomy for embolic stroke	Physicians must attempt to re-establish cerebral blood flow in patients deemed as suitable candidates for EVT. Restricted to specialists with Neuroendovascular fellowship training.
Ophthalmology	New fee code	Gxxx	Pattern electroretinogram	

Constituency	Type	FC	Description	Details
Ophthalmology	New fee code	Gxxx	colour vision screening with permanent record	
Ophthalmology	New fee code	Gxxx	Full field stimulus threshold testing (FST)	
Ophthalmology	New fee code	Gxxx	Visual Evoked Response pattern reversal	
Ophthalmology	New fee code	Gxxx	Pupillometry	
Ophthalmology	New fee code	Exxx	Retinal imaging including peripheral retinal imaging by ultra-widefield or widefield fundus cameras	
Orthopaedic Surgery	New fee code	Rxx1	Flatfoot Correction	
Orthopaedic Surgery	New fee code	Rxx2	Cavovarus Foot Reconstruction	
Orthopaedic Surgery	New fee code	Rxx11	Multi ligament knee reconstruction– Acute	
Psychiatry	New fee code	Gxxx	repetitive Transcranial Magnetic Stimulation (rTMS)	Repetitive Transcranial Magnetic Stimulation is a treatment which has been shown to be effective in the treatment of clinical depression and other disorders.
Rheumatology	New fee code	Gxxx	Initiating or switching of biologic or small molecule advanced therapeutic	
Vascular Surgery	New fee code	Rxxx	Second Surgeon - Aorto-iliac and Visceral Vascular Surgery	75% of the procedural fee for open or endovascular aorto-iliac and visceral vascular surgery.

Appendix III: Submissions identified as complexity of patient care

Constituency	Type	FC	Description	Details
Allergy & Clinical Immunology	Value change	G208	Provocation testing, per unit	With the increased reliance on oral challenges as a gold standard, outpatient clinics are performing high-risk challenges routinely and as such should be compensated closer to the comparator of G190. Proposal may also help with Gender Pay Gap as more females bill this than males.
Anaesthesiology	Value change	ANA Units	Additional ANA units	Add one basic unit to all cases with 6 basic units or more whose average hourly rates fall below an hourly rate threshold.
Cardiac Surgery	Revision	E682	Pump bypass - graft of major vessel other than ascending aorta for the purpose of cardiopulmonary bypass or ventricular assist device, to E650 add	Allow E682 to be billed with R743 and R701-704
Dermatology	New fee code	Axxx	Complex Skin Cancer Specific Assessment	
Gastroenterology	Value change	E098	Gastroenterology chronic disease assessment premium	
General & Family Practice	New fee code		Complexity Modifier for Comprehensive Family Practice	The complexity modifier premium would be billed by family physicians providing longitudinal , comprehensive care or focused practice physicians that are seeing patients with complex medical issues as per proposed diagnostic code list
General Surgery	Value change	E673	Lysis of extensive intra-abdominal adhesions, add	
General Surgery	New fee code	Exxx	Suffix modifier for selected codes for a second general surgeon assisting another general surgeon	For listed surgical procedures, a second general surgeon is able to bill the same code at a reduced rate of 75%.
General Thoracic Surgery	Value change	M143	Lobectomy, may include radical mediastinal node dissection or sampling	Lobectomy/segementctomy is projected to become more difficult and in an increasingly older population. This increase in complexity should be reflected in an increase in fees.

Constituency	Type	FC	Description	Details
General Thoracic Surgery	Value change	M144	Segmental resection, including segmental bronchus and artery	Lobectomy/segementctomy is projected to become more difficult and in an increasingly older population. This increase in complexity should be reflected in an increase in fees.
General Thoracic Surgery	Value change	M145	Wedge resection of lung	Lobectomy/segementctomy is projected to become more difficult and in an increasingly older population. This increase in complexity should be reflected in an increase in fees.
General Thoracic Surgery	Value change	R940	Mesenteric or celiac artery repair – Pulmonary thromboendarterectomy (PTE) - includes circulatory arrest with hypothermia	The current fee value is vastly under-representing the complexity of the procedure.
General Thoracic Surgery	Value change	Z788	Extracorporeal Membrane Oxygenator (ECMO) - includes cannulating and decannulating, by any method heart, vein and/or artery and repair of vessels if rendered	The indications have also been broadened for ECMO in recent years with multi-centre trials and the recent COVID-19 pandemic demonstrating benefit from ECMO.
General Thoracic Surgery	Value Change and Revision	E618	- with decortication of remaining lobe(s), add	E618- with decortication of remaining lobes or major thoracic lysis of adhesions (over 1 hour)
General Thoracic Surgery	Revision	M106	Chest wall reconstruction - Mediastinal tumour	Allow with following E-codes with M106: E615, E611, E849, E848, E618, E620, E621, E608, E607
General Thoracic Surgery	Revision	E676	Obesity Premium add-on	At present the E676 is only available for open thoracic procedures. We propose expanding this for minimally invasive procedures as well due to increased challenges during the procedure as well as more difficult post-operative recovery.
General Thoracic Surgery	Revision	E683	when performed thoracopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach	Allow E683 to be billable with other common thoracic surgery procedures
General Thoracic Surgery	Revision	M138	Hilar lymph node or lung biopsy with full thoracotomy	Allow E683 (when performed thoracopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal

Constituency	Type	FC	Description	Details
				approach, to M138, add 35%) to be eligible with M138
Hospital Medicine	New fee code	Cxxx	Subsequent visit by the MRP - day of discharge, medically complex patient	* minimum of forty-five (45) minutes in patient care
Hospital Medicine	New fee code	Wxxx	Subsequent visit by the MRP - day of discharge, medically complex patient; long term care or chronic care facility	There is no fee code for discharging patients from long term care or chronic care let alone for medically complex patients.
Long Term Care & Care of the Elderly	Value change	W010	Monthly management of a Nursing Home or Home for the Aged Patient - Monthly management fee (per patient per month)	The Fixing LTC Homes Act of 2021(FLTCA) came into effect on April 11, 2022. This legislation has created changes to the work for physicians in LTC
Long Term Care & Care of the Elderly	Value change	W003	Nursing home or home for the aged - first 2 subsequent visits per patient per month, per visit	The Fixing LTC Homes Act of 2021(FLTCA) came into effect on April 11, 2022. This legislation has created changes to the work for physicians in LTC
Long Term Care & Care of the Elderly	Value change	W008	Additional subsequent visits (maximum 2 per patient per month) per visit	The Fixing LTC Homes Act of 2021(FLTCA) came into effect on April 11, 2022. This legislation has created changes to the work for physicians in LTC
Nephrology	Value change	E060	Post Renal Transplant Assessment Premium	
Neurology	New fee code	Axxx	Complex headache assessment	Must be claimed by an adult or pediatric neurologist.
Neurology	Revision	E150	CritiCall review of complex neurosurgical imaging, to K733	Revise descriptor from "complex neurosurgical imaging" to "complex neuroimaging" and allow Neurology to be eligible to bill.
Neurology	New fee code	Exxx	Chronic CNS disorders premium	* Chronic CNS disorder premium is applicable to 18(Neurology) and 26(Paediatrics) "A" assessment codes * Eligible chronic neurologic conditions: 346 Chronic migraine 306 Psychosomatic disturbances (functional neurological disorder), 335 Motor neuron disease, 358 Myasthenia gravis, 436 Stroke, 191 Malignant neoplasms (brain), 350 Trigeminal neuralgia, 349 Huntington’s chorea, 432 Intracranial hemorrhage.

Constituency	Type	FC	Description	Details
Neurology	New fee code	Axxx	Complex neuro-oncology assessment	A complex neuro-oncology assessment is an assessment for the ongoing management of applicable diseases of the central nervous system where the complexity of the neuro-oncological condition requires the continuing management by a neurologist.
Neurosurgery	Revision	E676	Morbidly obese patient premium	Allow E676 to be eligible with selected neurosurgical codes (e.g., spine).
Obstetrics & Gynaecology	New fee code	Sxxx	Pelvic mesh excision	Involves removal of a vaginal or pelvic mesh for chronic pain, urinary obstruction or chronic erosion.
Ophthalmology	Revision	E877	Strabismus procedures - repeat strabismus procedure(s), to E185, E184, E183, or E182, add 30%	Allow E877 to also be billable for strabismus procedures performed for patients with post traumatic strabismus, Thyroid eye disease. post placement of a retinal buckle, or external ophthalmoplegia
Ophthalmology	New fee code	Exxx	Pediatric cataract extraction age 0 to 7 years	
Ophthalmology	New fee code	Exxx	Pediatric cataract extraction age 8 to 16 years	
Paediatrics	Revision	E082	Admission assessment by the MRP	Revise payment rules to include sick newborns on first day of life as at present not eligible for payment for a patient admitted for obstetrical delivery or newborn
Paediatrics	Revision	A/C815	Midwife requested special assessment	Apply paediatric age premiums found on page GP64 to A/C815
Plastic Surgery	Revision		Free Island Flaps	Add note on page M20 indicating reduction doesn't apply to free island flap breast reconstruction following post-mastectomy or post-lumpectomy
Plastic Surgery	Revision	E832	Excision of fascia for Dupuytrens, one or more additional rays, to R551	Revise to pay for each additional ray.
Primary Care Solo Doctors	New fee code	Kxxx	Cancer patient comprehensive care - first 20 minutes	* It is intended to include any combination of assessment, counseling, and primary mental health care that might be needed to address the patient's concerns in that visit.
Psychiatry	New fee code	Kxxx	Level I modifier	The Section proposes expanding the system to provide additional "Clinical Care Modifiers" that identify and

Constituency	Type	FC	Description	Details
				recognize psychiatric services of higher comlexity/intensity/risk.
Psychiatry	New fee code	Kxxx	Level II modifier	The Section proposes expanding the system to provide additional "Clinical Care Modifiers" that identify and recognize psychiatric services of higher comlexity/intensity/risk.
Respiratory Diseases	Revision	G412	Nephrological component of renal transplantation-1st day following transplantation	Revise descriptor to: Nephrological or pulmonary component of organ transplantation
Respiratory Diseases	Revision	G408	Nephrological component of renal transplantation, 2nd to 10th day, inclusive per diem	Revise descriptor to: Nephrological or pulmonary component of organ transplantation
Respiratory Diseases	Revision	G409	Nephrological component of renal transplantation, 11th to 21st day, inclusive per diem	Revise descriptor to: Nephrological or pulmonary component of organ transplantation
Rheumatology	New fee code	Kxxx	Psoriatic arthritis management by a specialist-annual	This service includes all services related to the coordination, provision, and documentation of ongoing management, including documentation of all medical record requirements, using a planned care approach
Rheumatology	New fee code	Exxx	Geriatric premium	Applicable to fee codes: A486, A590, A595, A486, A483, A484, A481, A488 and A480
Urology	Revision	multiple	Incision - Slit of prepuce (complete care) -newborn (S567), infant (S568), adult or child (S569).	Change the "slit of prepuce" codes from S codes to Z codes: S567, S568, S569
Vascular Surgery	Revision	E078	Chronic disease assessment premium	* Vascular surgery encompasses both medical and surgical care for patients.

Appendix IV: Submissions identified as schedule modernization

Constituency	Type	FC	Description	Details
Addiction Medicine	Delete fee code	K682	Opioid Agonist Maintenance Program monthly management fee - intensive, per month	Delete K682 and re-invest funds into the K683.
Addiction Medicine	Value Change and Revision	K683	Opioid Agonist Maintenance Program monthly management fee - maintenance, per month	Delete K682 and re-invest funds into the K683.
Laboratory Medicine	Value change	L800	Haematopathology - Blood film interpretation (Romanowsky stain)	Aligned with those of the American Medical Association's work relative value units (WRVU), which is the best available empirically derived measures of laboratory physician work relative value.
Laboratory Medicine	Value change	L810	Anatomic Pathology - Cytopathology - Fluids e.g. pleural, ascitic cyst, pericardial, C.S.F., urine and joint	Aligned with those of the American Medical Association's work relative value units (WRVU), which is the best available empirically derived measures of laboratory physician work relative value.
Laboratory Medicine	Value change	L846	Special Procedures and Interpretation - Histology or Cytology - Flow cell cytometry and interpretation - per marker	Aligned with those of the American Medical Association's work relative value units (WRVU), which is the best available empirically derived measures of laboratory physician work relative value.
Anaesthesiology	New fee code	A/Cxxx	Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service)	The Section is requesting modernization of acute pain services by creation of new fee codes A/Cxxx with the deletion of A/C215 for Complex Post-Operative/Post-Partum Pain Management (Acute Pain Service)
Anaesthesiology	Revision	E084	Saturday, Sunday or Holiday Subsequent visit by the MRP premium, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982	add 01 Anesthesiology to the list of eligible specialties
Cardiac Surgery	Revision	E651	Excision - when done in conjunction with coronary artery repair, add	Add commentary clarifying there is no limit and remove

Constituency	Type	FC	Description	Details
				assessment by medical consultant requirement
Cardiac Surgery	Revision	E646	Coronary artery repair - vein patch angioplasty of coronary artery, add	Add commentary clarifying there is no limit
Cardiac Surgery	Revision	E654	Coronary artery repair - each additional, add	Delete Note #3 "Where a single segment of vein is used for more than 2 anastomoses, the second and subsequent anastomoses are to be claimed at 50% of the E654 fee"
Cardiac Surgery	New fee code	Axxx	Cardiac surgical consultation for regional service	
Critical Care Medicine	New fee code	Gxxx	Day 1 CCM per-diem	Create duplicate Critical Care per diem codes (G400A, G401A, G402A) billable only by OHIP Specialty "11" CCM specialists
Critical Care Medicine	New fee code	Gxxx	Days 2-30 CCM per-diem	Create duplicate Critical Care per diem codes (G400A, G401A, G402A) billable only by OHIP Specialty "11" CCM specialists
Critical Care Medicine	New fee code	Gxxx	Days >30 CCM per-diem	Create duplicate Critical Care per diem codes (G400A, G401A, G402A) billable only by OHIP Specialty "11" CCM specialists
Critical Care Medicine	New fee code	Gxxx	Day 1 Comprehensive CCM per-diem	Create duplicate Critical Care per diem codes (G557A, G558A, G559A) billable only by OHIP Specialty "11" CCM specialists
Critical Care Medicine	New fee code	Gxxx	Days 2-30 Comprehensive CCM per-diem	Create duplicate Critical Care per diem codes (G557A, G558A, G559A) billable only by OHIP Specialty "11" CCM specialists
Critical Care Medicine	New fee code	Gxxx	Days >30 Comprehensive CCM per-diem	Create duplicate Critical Care per diem codes (G557A, G558A, G559A) billable only by OHIP Specialty "11" CCM specialists
Critical Care Medicine	New fee code	Gxxx	ICU/NICU admission assessment is an initial visit rendered during evening time (17:00-24:00), to G400, G405, G557, G600, G603, G604, G610 or G620	Billed by MRP if initial assessment time occurs Mon-Fri 1700-2400h. G556A is equivalent to K996A + K964A therefore we have requested that the new fee code be equivalent to K994A + K962A

Constituency	Type	FC	Description	Details
Critical Care Medicine	New fee code	Gxxx	ICU/NICU admission assessment is an initial visit rendered during weekends and holidays time (07:00-24:00), to G400, G405, G557, G600, G603, G604, G610 or G620	Billed by MRP if initial assessment time occurs Sat, Sun or Holidays at 0700-2400h. G556A is equivalent to K996A + K964A therefore we have requested that the new fee code be equivalent to K998A + K963A
Critical Care Medicine	Revision	Multiple	Special Visit Premiums - Evening & Weekend	Allow person seen Special Visit Premiums (SVP) for evenings and weekends (K998, K999, C986, C987, K/C994, K/C995) be eligible for payment with Critical Care per diem fees
Dermatology	Revision	A020 A021	Complex dermatology assessment Advanced Dermatology Consultation	Clarify applicable medical indications for billing these fee codes
Diagnostic Imaging	Value Change and Revision	J182	Diagnostic Ultrasound J182 Extremities - per limb (excluding vascular studies)	Both extremity limbs. Removal of restriction to add doppler vascular study.
Emergency Medicine	Revision	H113	Emergency department service premium - daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays, per patient visit	Revise to allow H113 to be billed Evenings (17:00h – 24:00h) Monday to Friday.
Emergency Medicine	Revision	H13X & H15X	H13X Monday to Friday - Evenings (17:00h to 24:00h) H15X Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)	H13X codes would be applicable Monday to Thursday from 1700-0000. H15X codes would be applicable Friday 1700-0000 and Saturday and Sunday from 0800-0000.
Endocrinology & Metabolism	Value change and Revision	K045	Diabetes management by a specialist	The Section is proposing a reduction in the minimum number of visits needed to bill K045 from 4 to 3, and a fee increase from $76.20 to $83.80
Gastroenterology	New fee code	Exxx	Total excision of very large sessile polyp or lesion (>3cm) of the upper GI tract using endoscopy mucosal resection (EMR) technique through oesophageoscopy-gastroscopy, with or without duodenoscopy, and may include fulguration and hemostasis, each	
Gastroenterology	Revision	E785	Multiple screening biopsies (>34 sites) for malignant changes in ulcerative colitis, to Z491, Z492,	* Revise descriptor to multiple biopsies for surveillance of inflammatory bowel disease-associated colorectal cancer or

Constituency	Type	FC	Description	Details
			Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555…add	dysplasia * Add new payment rules.
General & Family Practice	Revision		Services provided after hours in small rural hospitals	* Services (visits such as A007 A003 A001) provided after hours in small rural hospitals * any visit billing code submitted with a hospital location code then they should be paid at full rate and not the reduced shadow billing rate.
General Surgery	New fee code	Rxxx	Minimal fee for procedure performed in an operating room under a general anesthetic	The constituency requested a new fee code as a minimal fee for procedure performed in an operating room under a general anaesthetic, paid at $200.00.
General Surgery	Value Change and Revision	S332	Herniotomy - Umbilical - adolescent or adult	(1) S332 - add language "with or without resection of incarcerated/strangulated contents" (2) With deletion of codes E756/E757
General Surgery	Value Change and Revision	S333	Herniotomy - Umbilical - Child (operative)	(1) S333 - add language "with or without resection of incarcerated/strangulated contents" (2) With deletion of codes E756/E757
General Surgery	Delete fee code	E756	with resection of strangulated contents, add	With S332 descriptor revision to "with or without resection of incarcerated/strangulated contents"
General Surgery	Delete fee code	E757	without resection of strangulated contents, add	With S332 descriptor revision to "with or without resection of incarcerated/strangulated contents"
General Surgery	Revision	A034	Partial assessment	A034 – assessments of less than 15 minutes. no change other than documenting time spent.
General Surgery	Revision	A033	Specific assessment	A033 – assessments of 15-30 minutes. no change other than documenting time spent.
General Surgery	New fee code	A0xx	assessments of greater than 30 minutes	

Constituency	Type	FC	Description	Details
General Thoracic Surgery	Value Change and Revision	M105	Chest wall tumour, resection of 2 or 3 ribs or cartilages	Chest wall resection - resection of 1 - 3 ribs or cartilages
General Thoracic Surgery	Delete fee code	Z353	Incisional biopsy of chest wall tumour	Z353 and Z354 are antiquated, rarely performed procedures, historically completed prior to the availability image guided core biopsies. If a surgical biopsy of a rib is required, this can be billed under rib resection, revised M105
General Thoracic Surgery	Delete fee code	Z354	Excisional biopsy of rib for tumour	Z353 and Z354 are antiquated, rarely performed procedures, historically completed prior to the availability image guided core biopsies. If a surgical biopsy of a rib is required, this can be billed under rib resection, revised M105
General Thoracic Surgery	Delete fee code	Z337	Rib resection for drainage	Z337 is a rarely performed procedure. If a rib resection for drainage is required then this can be billed either as M105 for chest wall resection, or as Z357 Thoracic window creation, depending on the indication.
General Thoracic Surgery	Revision	Z332	Aspiration with therapeutic drainage with or without diagnostic sample	Thoracentesis - Aspiration for diagnosis or therapeutic drainage
General Thoracic Surgery	Delete fee code	Z331	Aspiration for diagnostic sample	Z331 will be combined as part of the revised Z332 to more accurately represent the risk of thoracentesis when performed for either indication.
General Thoracic Surgery	Delete fee code	Z333	Endoscopy - with transbronchial biopsy under image intensification (including bronchoscopy)	Z333 is historical and not being currently performed
General Thoracic Surgery	Value change and Revision	Z352	Intrapleural administration of thrombolytic or fibrinolytic agent via thoracostomy tube (chest tube)	* Coalescing the two codes of Z349 and Z352 into Z352 will reduce redundancy and more accurately represent the procedure including the risk of administering medication through a chest tube.
General Thoracic Surgery	Delete fee code	Z349	Intrapleural administration of chemotherapy or sclerosing agent - by any method	Coalescing the two codes of Z349 and Z352 into Z352 will reduce redundancy and more accurately represent the procedure including the risk of

Constituency	Type	FC	Description	Details
				administering medication through a chest tube.
General Thoracic Surgery	Delete fee code	Z338	Biopsy of pleura or lung - with limited thoracotomy	Z338 is no longer performed with the ability to complete VATS surgery. When a pleural biopsy is required, this is completed VATS and can be billed more appropriately as Z335. If a lung biopsy is being completed, then this is usually M145 or a VATS wedge resection to reflect the lung resection.
General Thoracic Surgery	Value change and revision	N284	Chest wall reconstruction - Excision of first rib and/or cervical rib to include scalenotomy when required	Excision of first rib and/or cervical rib to include scalenotomy, fibrolysis and neurolysis when required
General Thoracic Surgery	Value change and revision	E616	- bi-lobectomy on right side, add	bi-lobectomy on right side or segmentectomy plus lobectomy (same side)
Genetics	New fee code	Kxxx	Genetic Clinical Analysis and Care Planning	$44.00 per 10 minutes with a maximum of 8 units per physician, per patient, per 12-month period
Haematology & Medical Oncology	Value change and revision	G388	Management of special oral chemotherapy, for malignant disease	No maximum per 12 month
Hospital Medicine	New fee code	Cxxx	Inpatient transfer of care	* minimum of 10 minutes work * complex patients include those with 3 or more diagnoses * add-on to C122, C123, C002, C007, C009, C132, C137, C139, C142, C143, W002 and W001
Hospital Medicine	Revision	N/A	Admission Assessment – General Requirements - Payment Rule 3 amendment	Revise payment rule 4 outlined in GP40.
Internal Medicine	Revision	N/A	Hospitalist Premium	Add W002, C121, W121 to the list of qualifying services.
Internal Medicine	Value Change and Revision	E084A	Weekend MRP premium	(1) Elimination of (a) E082 payment rule #2 and (b) E083 and E084 payment rule #4; (2) Include C121, W002 and W132 as an eligible code for E083 and E084 premiums; and

Constituency	Type	FC	Description	Details
				(3) Increase E084 from 45% to 95%
Laboratory Medicine	Delete fee code	L801	Anatomic Pathology - Surgical Pathology - Metabolic bone studies	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L833	Anatomic Pathology - Surgical Pathology - Nerve teasing	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L807	Cytogenetics - Smear for sex chromatin (Barr Body) or Neutrophil drumsticks	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L811	Cytogenetics - Y chromosome	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L803	Cytogenetics - Karyotype	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L832	Special Procedures and Interpretation - Histology or Cytology - X-ray diffraction analysis and interpretation	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L831	Special Procedures and Interpretation - Histology or Cytology - analytical electron microscopy, elemental detection or mapping, electron diffraction, per case, add	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L847	Special Procedures and Interpretation - Histology or Cytology - Caffeine - halothane contracture test and other confirmatory tests for malignant hyperthermia	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L828	Biochemistry and Immunology - Interpretation of hormone receptors for carcinoma to include estrogen and/or progesterone assays	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L830	Haematopathology - Terminal transferase by immunofluorescence	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L838	Haematopathology - Leukocyte phenotyping by monoclonal antibody technique	deletion as a result of change in practice
Laboratory Medicine	Delete fee code	L827	Biochemistry and Immunology - Interpretation of carcinoembryonic antigen (CEA)	deletion due to absent professional involvement
Laboratory Medicine	Delete fee code	L849	Special Procedures and Interpretation - Histology or Cytology - Interpretation and handling of decalcified tissue	deletion due to absent professional involvement

Constituency	Type	FC	Description	Details
Laboratory Medicine	Delete fee code	L834	Special Procedures and Interpretation - Histology or Cytology - Histochemistry of muscle - 1 to 3 enzymes	deletion for simplification
Laboratory Medicine	Delete fee code	L835	Special Procedures and Interpretation - Histology or Cytology - each additional enzyme, add	deletion for simplification
Laboratory Medicine	Delete fee code	L825	Anatomic Pathology - Cytopathology - Compensated polarized light microscopy for synovial fluid crystals	deletion for simplification
Laboratory Medicine	Delete fee code	L843	Special microscopy of tissues including polarization interference phase-contrast, dark field, autofluorescence or other microscopy and interpretation	Revision to L844 would allow to include both codes L843 & L844.
Laboratory Medicine	Revision	L848	Anatomic Pathology - Cytopathology - Seminal fluid analysis - quantitative kinetic studies, including velocity linearity and lateral head amplitude	Seminal fluid analysis - quantitative kinetic studies
Laboratory Medicine	Revision	L841	Special Procedures and Interpretation - Histology or Cytology - Enzyme histochemistry and interpretation - per enzyme	Immunohistochemistry, direct immunofluorescence, in situ hybridization, immunobead or other detection method and interpretation per marker
Laboratory Medicine	Revision	L823	Anatomic Pathology - Surgical Pathology - each subsequent frozen section or direct smear and/orselection of tissue for biochemical assay e.g. estrogenreceptors, add	- each subsequent frozen section or direct smear
Laboratory Medicine	Revision	L822	Anatomic Pathology - Surgical Pathology - Operative consultation, with or without frozen section	Operative consultation, with or without frozen section or direct smear
Laboratory Medicine	Revision	L844	Special Procedures and Interpretation - Histology or Cytology - Special microscopy of fluids (polarization, interference, phasecontrast, dark field, autofluorescence or other microscopy and interpretation)	Special microscopy including polarization, phase-contrast, differential interference contrast, dark field, autofluorescence or other microscopy and interpretation
Laboratory Medicine	Revision	L837	Special Procedures and Interpretation - Histology or Cytology - Immunohistochemistry and interpretation - per marker	Immunohistochemistry, direct immunofluorescence, in situ hybridization, immunobead or other method and interpretation - per marker

Constituency	Type	FC	Description	Details
Long Term Care & Care of the Elderly	New fee code	Wxxx	LTC telephone support	This is the service initiated by a physician where a physician provides telephone support to a caregiver(s) for a patient residing in LTC.
Long Term Care & Care of the Elderly	Revision	K042	Extended specific neurocognitive assessment	Allow physicians with the COE (Care of the Elderly) designation or has an exemption to access bonus impact in Care of the Elderly from the MOH to be eligible to bill K042.
Multiple	Revision	Axxx	Complex Medical Specific reassessment	Revise annual limits to allow 6 per 12 month
Multiple surgical sections			Surgical unbundling	Multiple Sections requested a revision to the Surgical Preamble to allow pre- and post-operative care and visits to be billed.
Multiple surgical sections			Complex time base surgical code	PPC Major Initiatives
Neurology	Delete fee code	G419	Tensilon test	The service should no longer be provided as it no longer falls within evidence-based practice. There are now safer ways to diagnose myasthenia gravis and this code is obsolete.
Nuclear Medicine	Revision	J809	Myocardial Perfusion Scintigraphy - application of (SPECT), maximum two per examination, to J808	Myocardial Perfusion Scintigraphy - application of SPECT (maximum 3 per examination), to J807 or J808
Nuclear Medicine	Revision	J866	Application of (SPECT), maximum one per examination, to J807	J866 has 2 separate listings in the SOB: -Page B3: Myocardial Perfusion Scintigraphy -application of SPECT (maximum 1 per examination), to J807 -Page B10: Application of Tomography (SPECT), other than to J808 or J852 -maximum one per Nuclear Medicine examination Page B3: Delete this listing entirely Page B10: Application of Tomography (SPECT), other than to J807, J808, or J852 -

Constituency	Type	FC	Description	Details
				maximum one per Nuclear Medicine examination
Nuclear Medicine	Value change and Revision	A735	Diagnostic consultation	Add the following: When the diagnostic consultation is done for a PET scan, add 50%.
Nuclear Medicine	New fee code	Jxxx	Brain scintigraphy - cerebral perfusion	Split J858 - Brain scintigraphy into two separate codes for perfusion and non-perfusion studies
Nuclear Medicine	New fee code	Jxxx	First hybrid tomographic (SPECT/CT) sequence	* Provide an increase in the value for the hybrid codes (Jxx1, Jxx2, and Jxx4) compared to the underlying non-hybrid base codes (J866 and J819). * Additionally, we are raising the possibility of using a modifier instead of separate codes for hybrid procedures. For example, we could bill Y866 instead of J866 when hybrid imaging is performed, with either an additional percentage or dollar value added to the J866 base amount.
Nuclear Medicine	New fee code	Jxxx	Subsequent hybrid tomographic (SPECT/CT) sequence	
Nuclear Medicine	New fee code	Jxxx	SPECT/CT - where each data set represents a different body area, maximum 3 images per examination	Currently billed as J819.
Nuclear Medicine	Revision	J819	where each SPECT image represents a different organ or body area, to J852, maximum 3 images per examination	Allow with J853 (instead of J866)
Nuclear Medicine	Value Change and Revision	J700	PET - Solitary pulmonary nodule	Modernize current list of PET fee codes such that it is simpler

Constituency	Type	FC	Description	Details
Nuclear Medicine	New fee code	Jxxx	PET - Cardiology	Modernize current list of PET fee codes such that it is simpler
Nuclear Medicine	New fee code	Jxxx	PET - Neurology	Modernize current list of PET fee codes such that it is simpler
Nuclear Medicine	Value Change and Revision	Jxxx	PET - Other	Modernize current list of PET fee codes such that it is simpler
Nuclear Medicine	Revision	J810	Myocardial scintigraphy - acute infarction, injury, inflammation, infiltration	Modernization of cardiac Nuclear Medicine studies on page B4 * Descriptor revision
Nuclear Medicine	New fee code	Jxx1	Myocardial Perfusion Scintigraphy - wall motion assessment - first analysis (maximum of 1 per exam)	Modernization of cardiac Nuclear Medicine studies on page B4 * currently billed as J813 at $62.50
Nuclear Medicine	New fee code	Jxx2	Myocardial Perfusion Scintigraphy - wall motion assessment - subsequent analysis (maximum of 1 per exam)	Modernization of cardiac Nuclear Medicine studies on page B4 * currently billed as J814 at $33.00
Nuclear Medicine	Revision	J820	Parathyroid scintigraphy - dual isotope technique with T1201 and Tc99m Iodine	Descriptor revision to reflect modern day practice. New descriptor: * Parathyroid scintigraphy
Nuclear Medicine	Revision	J857	CSF circulation - with Tc99m or I-131 HSA	Descriptor revision to reflect modern day practice. New descriptor: * with Tc-99m
Nuclear Medicine	Value Change and Revision	J860	Perfusion and ventilation scintigraphy - same day	Descriptor revision to reflect modern day practice. New descriptor: * Ventilation and perfusion (V/Q) scintigraphy - same day
Nuclear Medicine	Revision	J865	Total body counting	Descriptor revision to reflect modern day practice. New descriptor: * Total body counting including dosimetry
Nuclear Medicine	Revision	J869	Adrenal scintigraphy - with MIBG	Descriptor revision to reflect modern day practice. New descriptor: * Adrenal scintigraphy
Nuclear Medicine	Revision	J830	Abdominal scintigraphy - for gastrointestinal bleed - Tc99m sulphur colloid or Tc04	Descriptor revision to reflect modern day practice. New descriptor: * with Tc-99m sulphur colloid or pertechnetate

Constituency	Type	FC	Description	Details
Nuclear Medicine	Revision	J878	Abdominal scintigraphy - for gastrointestinal bleed - labelled RBCs	Descriptor revision to reflect modern day practice. New descriptor: * RBC scintigraphy
Obstetrics & Gynaecology	New fee code	Pxxx	Management of labour	Requires completion of written record. Payable only after at least one hour of attendance at bedside. Payable once per obstetrician but can be billed by any obstetrician managing more than one hour of complex labour.
Obstetrics & Gynaecology	Value change and Revision	S725	Colpocleisis (LeFort or modification)	Colpocleisis or vaginectomy
Obstetrics & Gynaecology	Delete fee code	S727	Ovarian debulking, for ovarian carcinoma of stage 2C, 3B, 3C, or 4 and may include hysterectomy, omentectomy, bowel resection, one or more biopsies and/or resection of pelvic peritoneum	The constituency requested the deletion of S727 and introduction of 4 separate new fee codes
Obstetrics & Gynaecology	New fee code	Sxxx	Stripping bladder peritoneum with cancer	Currently bundled under S727; proposal to unbundle services and sunset S727
Obstetrics & Gynaecology	New fee code	Sxxx	Stripping large/ small bowel mesentary with cancer	Currently bundled under S727; proposal to unbundle services and sunset S727
Obstetrics & Gynaecology	New fee code	Sxxx	Resection of diaphragmatic disease from cancer	Currently bundled under S727; proposal to unbundle services and sunset S727
Obstetrics & Gynaecology	New fee code	Sxxx	Resection of omental cake from cancer	Currently bundled under S727; proposal to unbundle services and sunset S727
Obstetrics & Gynaecology	Revision	P020	Operative delivery, i.e. mid-cavity extraction or assisted breechdelivery	Revise descriptor to: Operative delivery, i.e. forceps or vacuum-assisted delivery, breech delivery, shoulder dystocia using advanced manoeuvers or greater than 1 minute in duration and/or urgent referral to the obstetrician on call for assistance.
Obstetrics & Gynaecology	New fee code	Zxxx	Insertion of hormonal implant or rod for contraception, menstrual cycle control or menopausal hormone therapy	* Currently billing the endocrinology code G342 ($31.05) as a proxy. However, implantation of contraceptive rods requires special training, a sterile field, local anesthetic.

Constituency	Type	FC	Description	Details
				* E542 (when performed outside hospital) would be eligible for payment in addition to the new Zxxx fee
Obstetrics & Gynaecology	Value change and Revision	Z463	Removal of Norplant	* Revise descriptor to: Removal of contraceptive or hormonal rod or pellet requiring skin incision & dissection. * E542 (when performed outside hospital) would be eligible for payment in addition to the new Zxxx fee
Obstetrics & Gynaecology	Revision	E090	Oophorectomy - removal of contralateral ovary with moderate or severe endometriosis, to S745, add	Revise to: Removal of contralateral ovary
Ophthalmology	New fee code	Exxx	Laser retinopexy for retinoblastoma	This service has been billed under the E154 code, which does not recognize the time risk and expertise required to perform this service. This service is most similar to the E125 procedure (laser retinopexy for retinopathy of prematurity).
Ophthalmology	New fee code	Exxx	Cryopexy for retinoblastoma	This service has been billed under the E155 code, which does not recognize the time risk and expertise required to perform this service. The fee has been adjusted for time and expertise relative to the E125.
Ophthalmology	Revision	Z901	Irrigation of nasolacrimal syst em - unilateral or bilateral	Revise from "unilateral or bilateral" to "per eye"
Ophthalmology	Value change	E194	Distichiasis - unilateral	
Ophthalmology	Delete fee code	E195	Trichiasis, repair by tarsal transplantation	Combined with E194
Ophthalmology	Value change and Revision	Z857	Epilation -by hyfrecator, electrolysis	Per eye.
Ophthalmology	Delete fee code	Z858	Epilation -by cryopexy	Combine with Z857.
Ophthalmology	Value change	E196	Entropion, other than Zeigler puncture	Entropion. Should be able to be billed with E930.

Constituency	Type	FC	Description	Details
	and Revision			
Ophthalmology	Value change and Revision	E197	Ectropion, other than Zeigler puncture	Zeigler puncture should be removed as this is rarely done. Should be able to be billed with E930.
Ophthalmology	Value change and Revision	E945	Entropion, other than Zeigler puncture - repeat by second surgeon, add	Proposed descriptor: Repeat
Ophthalmology	Value change and Revision	E948	Ocular and Aural Surgical Procedures - with mucous membrane graft, add	with mucous membrane graft or amniotic membrane or spacer graft
Ophthalmology	Value change and Revision	E210	Excision of conjunctival lesion	Add: "presumed malignant"
Ophthalmology	Value change and Revision	E169	Decompression - two walls	Revised descriptor to "2 or more walls"
Ophthalmology	Delete fee code	E170	Decompression - three walls	Combine with E169
Ophthalmology	Revision	E157	Placement and suturing of iris prosthetic device with or without suturing of iris/pupillary defect.	Revised descriptor: Placement and/or suturing of iris prosthetic device with or without suturing of iris/pupillary defect .
Ophthalmology	Revision	E138	Fixation of intraocular lens and/or capsular tension device by suturing	Revised descriptor: Fixation of intraocular lens and/or capsular tension device by suturing and/or direct fixation
Ophthalmology	New fee code	Exxx	Pneumatic Retinopexy	* Payment rules: E148, E142, E149, E147, E175, Z851 not eligible for payment with this code on the same day. * Paid by MoH under IC at $160 (Z851 + E149)
Ophthalmology	Revision	E151	Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as aninitial procedure	Revised descriptor: Retinal laser photocoagulation or cryopexy for treatment of retinal tear or retinal detachment.
Ophthalmology	Revision	E154	Photocoagulation (xenon, argon laser, etc.) - one eye	Revised descriptor: Retinal laser photocoagulation of retinal lesion or for panretinal photocoagulation or focal macular treatment.

Constituency	Type	FC	Description	Details
Ophthalmology	Revision	E940	Anterior vitrectomy - when done in conjunction with another intraocular procedure, add	Revised descriptor: Anterior vitrectomy by corneal or pars plana approach, in conjunction with another intraocular procedure.
Ophthalmology	Value change and Revision	E148	Vitrectomy by infusionsuction cutter technique	* Combine E148 (Vitrectomy by infusion suction cutter technique) AND E936 (Vitreous exchange - to vitrectomy) *Proposed descriptor: Vitrectomy, complete and by posterior approach, with vitreous exchange (air, gas, or artificial vitreous substance)
Ophthalmology	Delete fee code	E936	Vitreous exchange - to vitrectomy	* Combine E936 (Vitreous exchange - to vitrectomy) with E148 (Vitrectomy by infusion suction cutter technique) and E142 (Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation)
Ophthalmology	New fee code	Exxx	Vitrectomy, complete and by posterior approach, with preretinal membrane peeling or segmentation, and vitreous exchange (air, gas, or artificial vitreous substance)	This combines E142 $830.00 with E936 $90.00. This is a cost-neutral proposal.
Ophthalmology	Delete fee code	E142	Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation.	A new code will be created that combines E142 with E936.
Ophthalmology	New fee code	Exx3	Vitrectomy, complete and by posterior approach, with cataract extraction, by phacoemulsification including insertion of intraocular lens	* This is a NEW code proposed for a combination of existing surgeries: cataract by phacoemulsification, with insertion of IOL, with posterior vitrectomy: * [**New E148 ($810.00) + E140 (at 85% of $397.75)] * The combination of codes avoids the huge problem of manual reviews and the administrative burden on MoH and physicians submitting billing.

Constituency	Type	FC	Description	Details
Ophthalmology	New fee code	Exx4	Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, without intraocular lens insertion patient left aphakic	* Dropped crystalline lens, patient left aphakic (without an intraocular lens implant)" * [**New E148 ($810.00) + E141 (at 85% of $505.45)]
Ophthalmology	New fee code	Exx5	Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, with intraocular lens insertion	* A cost-neutral combination of current codes is proposed: * [**New E148 ($810.00) + E141 (at 85% of $505.45) + E950 (at 85% of $92.50)]
Ophthalmology	New fee code	Exx6	Vitrectomy, complete and by posterior approach, with dislocated crystalline lens or retained nuclear fragment extraction from the posterior segment by fragmatome, and with insertion and fixation of IOL by suturing, trans-scleral haptic fixation, or iris fixation	* A combination of services is proposed. This is a cost-neutral proposal. *[**New E148 ($810.00) + E141 (at 85% of $450.00) + E138 (at 85% of $450.00)
Ophthalmology	New fee code	Exx7	Vitrectomy, complete and by posterior approach, removal of IOL, and with insertion and fixation of IOL by suturing, trans-scleral haptic fixation, or iris fixation	* A combination of services is proposed. This is a cost-neutral proposal. *[**New E148 ($810.00) + E144 (at 85% of $450.00) + E138 (at 85% of $450.00)]
Ophthalmology	New fee code	Exx8	Vitrectomy, complete and by posterior approach, with membrane peeling, photocoagulation, and cataract extraction, by phacoemulsification including insertion of intraocular lens	*A combination of services is proposed. This is a cost-neutral proposal. * [**New E142 ($920.00) + E140 (at 85% of $397.75)]
Ophthalmology	New fee code	Exx9	Vitrectomy for repair of retinal detachment, including photocoagulation, and cataract, by phacoemulsification including insertion of intraocular lens	* A combination of services is proposed. This is a cost-neutral proposal. *[**New E148 ($810.00) + E151 (at 85% of $282.65) + E140 (at 85% of $397.75)]
Ophthalmology	Revision	G820	OCT unilateral or bilateral - glaucoma, when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	Payment rule 6. G820 is limited to a maximum of 2 4 services per patient per 12 month period. Exclude/remove G820 from the Payment rule #2 "G822 is only eligible for payment when the limit of any

Constituency	Type	FC	Description	Details
				combination of G818, G820 or G821 is reached."
Ophthalmology	Value change and revision	G822	OCT unilateral or bilateral -active management with laser or intravitreal injections for neovascularization associated with: i. retinal disease, e.g. wet acute macular degeneration; ii. diabetic macular edema; or iii. retinal vein occlusion when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	Remove Payment Rule #2 "G822 is only eligible for payment when the limit of any combination of G818, G820 or G821is reached" or exclude G820 (glaucoma) from payment rules.
Ophthalmology	Value change and revision	G813	Corneal pachymetry, professional component	Proposed payment rule change: This service is limited to one per patient per lifetime year. Services in excess of this limit, or rendered for any purpose other than identifying patients at risk for glaucoma, are not insured services.
Ophthalmology	Revision	E132	Glaucoma filtering procedures	Revised descriptor: Glaucoma surgical procedure to include both angle and subconjunctival based surgery
Ophthalmology	Revision	E983	Glaucoma filtering procedures - following previous glaucoma filtering procedure, to E132, add	Revise to include previous retinal scleral buckling procedures: "following previous glaucoma filtering procedure or previous retinal sckeral buckling procedures"
Ophthalmology	Revision	E214	Glaucoma filtering procedure and cataract extraction (same eye)	Revised descriptor: Glaucoma surgical procedure to include both angle and subconjunctival based surgery and cataract extraction (same eye).
Ophthalmology	Revision	E984	Glaucoma filtering procedure and cataract extraction (same eye) - following previous glaucoma filtering procedure, to E214, add	Revised descriptor: following previous glaucoma filtering procedure or previous retinal sckeral buckling procedures, to E214 add

Constituency	Type	FC	Description	Details
Ophthalmology	Revision	E123	Division of iris to cornea	Revised descriptor: Division of iris to cornea and/or angle
Ophthalmology	New fee code	Exxx	#E150 - cyclo-photocoagulation/ablation/destruction (laser to the ciliary body) - either trans-scleral or endoscopic	billed as E134 Laser angle surgery ($205.55)
Ophthalmology	Revision	U236	Follow-up e-assessment	Allow code to be eligible for payment when referral originates from optometrist or a medical doctor.
Ophthalmology	Revision	U235	Initial e-assessment	Allow code to be eligible for payment when referral originates from optometrist or a medical doctor.
Orthopaedic Surgery	Revision	E676	Morbidly obese patient premium	Allow for Total Hip Replacements
Otolaryngology	New fee code	Axxx	Audiologist-requested assessment	Same fee as A245 Consultation
Otolaryngology	New fee code	Axxx	Special audiologist-requested assessment	* Same fee as A935 Special surgical consultation * Minimum of 50 minutes of direct contact with the patient
Otolaryngology	New fee code	Axxx	Dentist-requested assessment	Same fee as A245 Consultation
Otolaryngology	New fee code	Axxx	Special dentist-requested assessment	* Same fee as A935 Special surgical consultation * Minimum of 50 minutes of direct contact with the patient
Otolaryngology	Revision	M090	Laryngoplasty - e.g. repair of stenosis and fractures transections - not to be billed with M084	Request for the addition of 6 assistant basic units
Otolaryngology	Revision	M080	Teflon augmentation larynx	Request for the addition of assistant basic units
Paediatrics	New fee code	Axx1	Consultation (minimum 45 min)	
Paediatrics	New fee code	Axx2	Consultation (minimum 60 min)	
Plastic Surgery	Revision	Z142	Reduction mammoplasty and augmentation mammoplasty (other than postmastectomy breast reconstruction) - Removal of breast prosthesis	Clarification of payment rules in Schedule for whether Z142 is eligible/ineligible for payment with Z135 or Z182 when performed on the same (ipsilateral) breast.

Constituency	Type	FC	Description	Details
Plastic Surgery	Revision	Multiple fee codes	Multiple skin cancer excisions/ reconstructions	Multiple skin cancer excisions/ reconstructions on the same patient on the same date not being paid. Clarification of payment rules around maximum number of procedures per patient per day in Schedule.
Plastic Surgery	Revision	R110	Reduction mammoplasty and augmentation mammoplasty (other than postmastectomy breast reconstruction) - Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral	Descriptor revision to allow access to reduction mammoplasty for patients as a first stage procedure, with scheduled nipple sparing mastectomy as a second stage.
Plastic Surgery	Revision	R118	Post Mastectomy Breast Reconstruction - Breast skin reconstruction by local f laps or grafts	Revise descriptor and notes associated with R118
Primary Care Solo Doctors	New fee code	Axxx	Same day urgent follow-up	For situations where the physician has assessed the patient in an office or home visit (A007, A003, A900, possibly K005), and felt the situation was serious enough that urgent investigations were ordered for that day, physician requested or expected the results would come back that day. The physician then interpreted those results and contacted the patient the same day to arrange further treatment for that day or the subsequent day.
Respiratory Diseases	New fee code	Kxxx	Multidisciplinary Respiratory Case Conference	
Rheumatology	Value change and Revision	G370	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath	Proposed Descriptor: Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath. (should delete - Only one of G370, G371, G328 and G329 is eligible for payment for the same bursa, joint or complex joint, and Aspiration and/or injection of the olecranon bursa is only eligible for payment as G370/G371 (under payment rules). Also, should revise under

Constituency	Type	FC	Description	Details
				"note" to include ALL JOINTS. There should be no distinction between a complex and non-complex joint
Rheumatology	Value change and Revision	G371	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath - each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5	Descriptor should be the same as G370.
Rheumatology	Value change and Revision	G328	Aspiration of bursa or complex joint, with or without injection	Proposed Descriptor: Aspiration of a bursa or joint, with or without injection (should delete from payment rules. Only one of G370, G371, G328 and G329 is eligible for payment for the same bursa, joint or complex joint, and Aspiration and/or injection of the olecranon bursa is only eligible for payment as G370/G371 (under payment rules). Also, should revise under "note" to include ALL JOINTS. There should be NO distinction between a complex and non-complex joint. All joints aspirated or injected take time and expertise, and the physician should be remunerated for the time and expertise taken to complete the procedure.
Rheumatology	Value change and Revision	G329	Aspiration of bursa or complex joint, with or without injection - each additional bursa or complex joint, to a maximum of 2	Descriptor should be the same as G328.
Surgical Assistants	Revision	Multiple fee codes	Surgical Assistants Special Visit Premiums Modernization	* Revision to table of fees for Special Visit Premiums for Surgical Assistant Services.

Appendix V : Provincial Comparison Family Medicine Payment Models

Ontario, British Columbia, Newfoundland & Labrador, Manitoba, Nova Scotia and Saskatchewan

Prepared by OMA Economics, Policy and Research. February 2024.

Category	ON FHO Model	BC Longitudinal Family Physician Payment Model	NL Blended Capitation Model Further information can be found here.	MB Longitudinal Family Practice Model	NS Longitudinal Family Medicine Payment Model	Sask. Transitional Payment Model (TPM)
Overview	The Family Health Organization (FHO) is a collaborative comprehensive primary care delivery model involving six or more physicians practicing in close proximately.	The LFP Payment Model is a compensation option for family physicians who provide longitudinal, relationship-based, family medicine care to a known panel of patients, aligned with the attributes of a Patient Medical Home.	Blended Capitation is a voluntary payment option for independent community-based family physicians. Each physician decides how many patients will be in their practice & rosters them (patients agree to belong). Physician receives an annual payment to provide comprehensive primary care to each patient, regardless of the number of patient encounters. Must form a group of minimum 3 physicians. Co-location is not a requirement; groups do not have to be under the same roof.	The Family Medicine Plus is a longitudinal family practice model, starting April 1, 2024. This model will offer more predictable non-volume-based funding, flexibility, and significantly increased funding for family medicine practices.	The Longitudinal Family Medicine (LFM) payment model is a new payment model that aims to provide stable, equitable funding for physicians who provide longitudinal family medicine, with a particular focus on access and attachment. The LFM model offers competitive compensation and enhanced accountability, through a blended payment that is calculated based on hours worked, services delivered and panel size.	To recognize and value the unique relationship between longitudinal FFS Family Physicians and their patients and the unpaid work resulting from this relationship, the TPM was developed. The model pays FFS family physicians volume of service, unpaid work and patient panel size.
Who is Eligible	General Practitioners	Family Physicians who:	Community Based Family Physician.	Family Physicians	All family physicians (those practicing in a	Family Physicians

Category	ON FHO Model	BC Longitudinal Family Physician Payment Model	NL Blended Capitation Model Further information can be found here.	MB Longitudinal Family Practice Model	NS Longitudinal Family Medicine Payment Model	Sask. Transitional Payment Model (TPM)
	(Managed Entry Guidelines apply) Minimum group size must be 6 physicians. Co-location and close proximately guidelines for all new FHO sites: • Minimum 3 physicians at each FHO site. • FHO's locations should be within a five-kilometre radius of one another, where a Rurality Index of Ontario (RIO) score is 0. • In areas with a RIO score of one or more, consideration will be given.	Provide the Required Services (see applicable row below). Contributes to rent, lease or ownership costs of clinic, as well as other operating costs (e.g. staffing, equipment, etc.). Has not withdrawn from LFP model in past 12 months. Not deemed ineligible by the Medical Services Commission.	<u>Eligibility Criteria</u> The minimum Blended Capitation Group size will be three physicians. • Commit to provide comprehensive continuous primary healthcare services across the life span of their patients, based on patient needs and responsive to documented needs of the geographic community they serve.		FFS model and those previously on APP model).	
How to the join model	Application process (Expression of Interest & Application form)	Submission of registration code each year between Jan 1 and Mar 31.	April 3rd, 2023: Open for applications. Application process (EOI and Practice Profile form used to determine eligibility as per Schedule R of the	Unknown	Application process	The TPM is voluntary and will have a separate process to sign-up (process and templates to be provided closer to April 2024).

Category	ON FHO Model	BC Longitudinal Family Physician Payment Model	NL Blended Capitation Model Further information can be found here.	MB Longitudinal Family Practice Model	NS Longitudinal Family Medicine Payment Model	Sask. Transitional Payment Model (TPM)
			Memorandum of Agreement (MOA) and is available in its entirety here. October 30, 2023: Start to issue notices of acceptance. thereafter 3-month processing time. April 1st, 2024: Billing system ready for testing-75 physicians. July 1st, 2024: Billing system open to all.			
Compensation Structure	• Capitation based on Age/Sex, approximately $200 per patient (includes CCM fee) • FFS • After-Hours • Bonuses	• Physician Time (Direct & Indirect, plus Clinical Administration Time) • Physician-Patient Interaction • Panel Payment	• Bi-weekly Capitation Payment. • $186.29 per patient (adjusted for complexity). • Annual Quality of Care Bonus: $7,500 • Annual Procedures Bonus: $2,500. • One-time transition grant: $11,250 • One-time start up grant: $10,000 • One-time EMR transition grant for practices not on provincial EMR: $30,000 per group • FFS Payment (25% of the value of MCP billings for direct patient encounters)	• FFS • $3.50 added to in-person visits to help offset increasing overhead costs (max of 50 claims per day). • Extended Visit payment for those more complex visits involving two or more complaints. Visits must last at least 20 minutes and involve assessing two or more systems. Payable at $70 per visit. • Panel payment for patients based on age and disease load. Avg $65-$85/patient/year. • Limited Time-Based stipend for indirect	• Hours worked: ➢ $92.70 / hr (weekdays) ➢ Hours worked: $139.05/ hr (evenings and weekends). • Services delivered: 30% of FFS, with enhanced fee codes in place. • Panel Size: $103 / patient. Will be adjusted for complexity at patient level eventually. As an interim measure, complexity is currently an add-on based on	• TPM provides a maximum $144,000 capitation payment; • Capitation payment takes into consideration unpaid work and patient panel. • Fee-for-service payments; • After-Hours Program provides $8 and $12 fee code add-ons after 5 p.m. and on weekends (for virtual care and in-person services, respectively).

Category	ON FHO Model	BC Longitudinal Family Physician Payment Model	NL Blended Capitation Model Further information can be found here.	MB Longitudinal Family Practice Model	NS Longitudinal Family Medicine Payment Model	Sask. Transitional Payment Model (TPM)
			• No negation • Two-year income guarantee while transitioning to new model, plus 10.9% premium in the first year	clinical services. $171.05/hr.	community-based complexity factors (socio-economic status; age; etc.). • Income smoothing: physicians paid bi-weekly and income smoothed for panel and hours payments (FFS payments are not smoothed). • Physicians new to family practice – guaranteed minimum income for one year.	
Outside Use (Negation)	Yes	No	No	No	No	No
Service Obligation: DAYTIME	Except for Recognized Holidays, the FHO Physicians shall ensure that a sufficient number of Physicians are available to provide the FHO Services during reasonable and regular office hours from Monday through Friday sufficient and	Provide LFP Practice Services for a minimum of one day per week, distributed equitably over the course of a year.	Reasonable, regular hours each week of the year. This obligation means that every doctor must make themselves available for reasonable and regular hours each week to schedule their rostered patients for routine appointments. The program will monitor the percentage of same-day or next-day appointments	The Physician or member of their team must provide: i) Medical services consistent with the applicable indicators in the Manitoba Primary Care Quality Indicators Guide (version 4.0 or such other version(s) as agreed to by the parties). https://www.gov.mb.ca/health/primarycare/providers/pin/docs/mpcqig.pdf	No required minimum daytime hours. Paid for hours worked. Model accepts full-time and part-time physicians.	No required minimum daytime hours.

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	convenient to serve Enrolled Patients. 2021 PSA Aspirational Targets: • For every 1,300 enrolled patients: 88 face-to-face and virtual patient encounters weekly, with 60 per cent or more being face to face patient encounters. • Group endeavor, measured every quarter.		made available to patients. The purpose of monitoring this indicator is to determine whether access is being maintained over time. If there is a decrease in access over time, groups are expected to take measures to restore this type of access to their practices. Non-binding aspirational standard of an average service level of not fewer than 88 Attached patient care encounters per 100 Attached patients each 3-month quarter (13 weeks).	ii) Ongoing coordination with other health care providers respecting management of patient condition(s) and patient care plan; and iii) Ongoing communication with patient, monitoring of patient condition(s) and patient care plan.		
Service Obligation: AFTER-HOURS	Evening and weekend 3-hour blocks, depending on size of group. 30% Premium	No set requirement. Cannot claim for after-hours for being on call, time and/or interaction codes can only be billed when providing LFP Practice Services.	Requires the group to schedule a portion of its work outside the 9-5, Monday-Friday window. Minimum of 3 after-hours clinic hours per week per group, with scaling based on number of attached patients to the group. For a transition period (up to August 31, 2025) physicians may apply for an after-hours exemption if they regularly provide services to the health	Not a requirement. 20% Premium.	After-Hours is 'encouraged' but not a requirement. 25% premium on FFS billings. Hours payment is time and a half ($139.05 vs $92.70).	After-Hours Program (With information given unable to tell if a requirement or not) $12 for certain after-hours in-person visits $8 for certain after-hours virtual visits.

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			authority – 2 hours of services to the health authority must be provided for every one hour of after-hours exempted. After-hours services may also be redistributed to a NP if the group hires one.			
Required Services	Provide, co-ordinate or oversee the provision of the FHO Services. After-Hours blocks.	Required Services: Provide Community Longitudinal Family Physician Services, aligned with the attributes of a Patient Medical Home Provide LFP Practice Services for a minimum of one day per week, distributed equitably over the course of a year. Ensure that Non-panel Services are no more than 30% of the total of LFP Practice Services and Non-panel Services in a calendar year. Develop and submit an accurate list of Empanelled within three months of enrolling in the LFP Payment Model. Have at least 250 Empanelled Patients within four months of enrolling in the LFP Payment Model.	Every doctor must make themselves available for reasonable and regular hours each week to schedule their rostered patients for routine appointments.	Unknown	Virtual care: Majority of patient services must be in-person Access: Must be providing service a minimum of 46 weeks of the year Hours claimed: 90% of hours billed under the LFM will be time delivering direct and indirect clinical services. 10% additional will be paid for time spent on Clinical Support Services (non patient-specific work associated with running the practice). Throughput: Physicians must complete a minimum of 2.8 service encounters per hour claimed under the LFM, on average	Longitude Care to a Panel Patient Establish a patient-physician compact /documentation (i.e. roster) emphasizing patient care. Develop and maintain an accurate list of rostered patients for statistical purposes. Adhere to chronic disease best practices. Follow common work standards for EMR/her patient-centered information exchange as developed by the EMR Co-Management Committee. Provided comprehensive care for empanelled patients. Where reasonable, address multiple

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		For full comprehensive list see Section 6 Required Services in LFP Payment Schedule			(applicable only to the direct and indirect clinical care hours claimed; not applicable to the 10% Clinical Support Services time claimed). After-hours care is encouraged (but not required). There may be additional access metrics in a year or so, but they are not settled on yet.	patient issues during the same visit. Patient's Medical Home Framework Commit to transition towards the Patient's medical home framework. Participate in a group with multiple MRPs in the TPM; all in group must share patient information, provide care and coverage to patients. Appoint one physician as the lead Provide on-call coverage to the group's patients. Rural TPMs must also be designated to a close emergency room. Enrol for the Primary Care Panel Report and commit to data tracking for improvement.
Included services	In-Basket Services – 19.41% shadow billing	LFP Practice Services (direct and indirect patient care); Non-panel Services; and	25% Shadow Billing 63 fee codes (does not include home	Fee codes – paid at full value.	Services paid at 30% FFS value. All in-office services for attached patients	Fee codes paid at full value.

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		Maternity Services	visits/personal care homes; flu/covid shots or Methadone/Suboxone monthly monitoring). See Schedule R, Appendix B for list: https://nlma.nl.ca/site/uploads/2023/10/2023.10.11-BCM-Schedule-Final-v2.pdf		(including home visits and inpatient visits mixed throughout the day/week) included. Services to unattached patients also included unless physician carves out a full-day or half-day window for unattached services only, in which case they are paid outside the LFM model at 100% FFS (with no LFM hours or panel payments applicable). LTC visits can be included or kept outside the LFM – physician designates as part of their Contracted Activities.	
Excluded Services	Out-of-basket services	Services to patients at acute care, hospice, palliative care or long-term care facility, including but not limited to hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.	Out-of-basket paid at full rate. Cap of $56,000 FFS billings for in-basket services provided to non-rostered patients per year.	Fee codes – paid at full value.	Out-of-office services such as ED, Hospitalist shifts, etc. generally outside the LFM. Services to unattached patients excluded only if done in a half-day clinic outside LFM hours.	Fee Codes paid at full value.

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		• Surgical procedures not listed in Appendix D • After-hours coverage (on call) time when not providing patient care • MAID • Services to residents of other Provinces/Territories/Countries • Motor Vehicle Accident and WorkSafeBC services • Uninsured Services • Services Provided under Health Authority Contract • Services insured by legislation other than the Medicare Protection Act			LTC visits can be included or kept outside the LFM – physician designates as part of their Contracted Activities.	
Rural Premium	Yes – based on RIO Score. To be eligible, a physician's OMA RIO Score must be at least 40 and above. The premium range is $5,000 to $15,000 per physician, depending on their RIO.	Yes - Rural physicians who practice in a Rural Practice Subsidiary Agreement (RSA) Community are eligible to receive rural premiums on LFP Payment Model payments.	N/A	New funding will create a Rural and Northern Retention Fund. This is expected to provide an estimated payment of over $25,000 per physician every three years, and this is in addition to the existing provincial Physician Retention Benefit payable every five years. New Remote Community 35% differential will apply to all medical care provided in remote communities, defined	No rural premium for family physicians. For specialists: Enhanced Rural Practice Specialist Support Program. For Rural Specialists only. Tier 1: $25,000 Tier 2: $16,000 *a rural specialist physician could obtain Tier 1, Tier 2 or both.	15% premium on FFS values for insured services provided in northern and rural Saskatchewan.

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				generally as communities north of the 53rd parallel but not Flin Flon, The Pas or Thompson, or communities south of the 53rd parallel and not having year-round road access. This new premium compliments the existing rural premium of 5% and northern premium of 25%. New funding models for physician coverage in rural hospitals and ERs will help to attract more physicians with competitive remuneration. A new $50 tariff is created to acknowledge the added work involved with receiving interfacility transfers in rural hospitals.		
Patient Complexity	As of April 1, 2024: risk-adjustment model based on the Canadian Institute for Health Information (CIHI) Population Grouping Methodology.	In 2023, the panel payment will be based on an interim methodology adapted from the Community Longitudinal Family Physician (CLFP) Payment to estimate the size and complexity of a longitudinal family physician's patient panel. In this interim methodology, the number of patients is estimated using the Majority	Built into panel payments.	Extended Visit payment for those more complex visits involving two or more complaints. Visits must last at least 20 minutes and involve assessing two or more systems. Payable at $70 per visit.	Panel payments will eventually be adjusted for complexity at patient level. Methodology not yet determined. As an interim measure, complexity is currently an add-on based on community-based complexity	Still to be developed.

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		Source of Care (MSOC) methodology and complexity is measured using the Adjusted Clinical Group (ACG) system. The panel payment is designed to be paid out four times per year on a quarterly installment schedule.			factors (socio-economic status; age; etc.). Complexity modifier ranges from 0.1% to 16.1%. It is currently applied to total LFM earnings.	
Billing for Time	N/A	Time codes for: • Direct Patient Care – per 15 min $32.50 • Indirect Patient Care – per 15 min $32.50 • Clinical Administration - per 15 min $32.50 *Locums paid at same rates. Patient care provided by non-physicians (e.g., nurses, nurse practitioners, allied care providers, nonclinical staff) is not payable under the LFP Payment Model. With the exception of the temporary LFP respiratory immunization when provided by an allied care provider. Max Daily Time: 14 hours in a single calendar day Max Two-Week Time: 120 hours in any 14 day period	N/A	Limited time-based stipend for indirect clinical services. 30 mins per 250 panel patients Hourly rate of $171.05 Max $513.15 per week.	• Hours worked: ➢ $92.70 / hr (weekdays) ➢ Hours worked: $139.05/ hr (evenings and weekends).	Does not contain an hourly rate nor a timesheet system at this time.

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		Max Clinical Administration time: 10% of total overall time.				
Billing for Physician Patient Interactions	FFS or Shadow Billing, depending on service.	• In-person Interaction in a Clinic $25 • Virtual Interaction by Phone or Video $25 • Minor Procedure or Diagnostic Test Provided with an In-person Interaction $10 • In-person Interaction with a Standard Procedure $60 • In-person Interaction with an Advanced Procedure $110 • In-person Interaction in the Patient's Home $100 • Consultation $60 • In-person or Video Group Interaction $25/patient (payable to a maximum of 9 patients for a group interaction 90 minutes or longer) Max 50 Physician-Patient Interaction codes in a single calendar day. Max 30% for Non-Panel Services in a calendar year.	FFS or Shadow Billing, depending on service.	Moving from 19 to four basic visit tariffs with add-ons for age premiums and for pelvic exams and cytological smears. The change will increase remuneration too.	FFS paid at 30%. Some enhanced billing codes that accompany the model (but are also available to FFS FPs): • Complex Patients: can bill multiples on prolonged visits. • New Patient Intake Fee: recognizes extra time spent onboarding new patients. • Patient-specific consults: patient specific consults with other health care professionals outside of the practice. • Telephone prescription renewals.	FFS
Roster Payment & Size	Age/Sex Adjusted currently, as of April 1, 2024 Risk Adjusted.	• Based on number of Empanelled Patient and	Age/Sex Adjusted currently. The maximum roster for each physician is 2,400	Panel Payment – ranges from $15 - $445, depending on age/complexity.	Panel Payment – Payment of $103 per patient was determined using	For payment under the TPM, panel sizes are determined by billing

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	Average FHO roster sizes should generally be no greater than 2400 patients on average per physician.	complexity of those patients. • Minimum panel size 250 Empanelled Patients.	patients, with the following possible modification: A group may expand their roster size if nurse practitioners or registered nurses are employed by or contracted to work as part of the group: 900 additional patients may be rostered by the group per NP, 600 additional patients per RN.	Avg: $65-$85 /patient. Paid quarterly.	target income ($365k for a 1.0 FTE), and weighing hours and 30% FFS. Government desire was to generate a meaningful amount of income from panel size. Will be adjusted for complexity to account for age, sex and socio-economic status, but currently complexity is as described above (based on community factors).	data and uses the 4-cut method. A patient is matched to only one family physician for payment purposes. The 4-cut method uses 3-years of billing data to calculate panel size for an individual physician.
FTE Measure	N/A	FTE in the LFP Model is measured as: • 1680 hours of patient care per year. • 5,000 Physician-Patient Interactions per year; and care to a patient panel that is the equivalent of 1250 Empanelled Patients of average complexity.	N/A	Unknown	N/A (model is available to full-time and part-time and payment is based on hours worked, panel size and FFS claims). FTE for modeling purposes assumed: - 1317 patients on panel - 1725 hours per year (including 184 hours in evenings) - $200k in FFS billings	As long as participating TPM physicians maintain a minimum panel size of 250 and meet the required accountabilities, there is no distinction between full-time and part-time.

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Preceptorship Support	Stipends are paid at the rate of $250.00 per week for eligible teaching activities, in accordance with provincial standards.	Time Codes are payable to physicians providing clinical teaching to Clinical Learners in relation to Clinic-Based Services. Patient-Interaction Codes for Clinic-based Services are payable to supervising physicians for patient interactions provided by students, residents, and trainees in specific circumstances.	Billing for insured services provided by medical learners, to support clinical teaching activities, will be at 100% FFS.		Effective Sept. 15, 2023, Dalhousie-approved preceptors will receive an annual $5,000 lump sum payment for committing to act as a preceptor and assess medical learners and practice-ready assessment physicians. In addition, preceptors will earn 5% on fee-for-service billings for services rendered while working with a trainee. Preceptors will also continue to receive $90/day when acting as a preceptor.	
Funding for Allied Health-Care Providers (AHCP)	Delegated Procedures as per the Schedule of Benefits.	Temporary LFP respiratory immunization when provided by an allied care provider employed by the physician/practice, October 1, 2023-March 31, 2024.	Revenue for practices who wish to hire/contract with NPs or RNs		On a pilot project basis, and only for those approved through an application process: Family physicians can bill for the services provided by the AHCP to help offset the costs associated with employing them, to a	Innovation Fund, $10 million annually. A fund to test to innovative ideas such as paying for additional clinical staff and/or non-physician providers. This fund will measure utilization, and support

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					maximum of $110,000 per year. • AHCP Service (simple): $25 • AHCP Service (complex): $52 *fees cannot be billed if the AHCP is paid for by the NSH or another third party.	physicians and clinics transition to physician led , team-based care.
Locum Coverage	Can join model – 12 months basis with possible renewal	Can provide locum coverage for an eligible Host Physician, short-term, long-term on on-going coverage for overflow/access.	Income to pay two-weeks of locum coverage.	Unknown	Family locum physicians: Minimum daily income guarantee $1,200. Travel Expenses: Mileage paid; accommodations to max of $300 per night; plus per diem of $100 per day for meals. Travel Time: $100/hr – max 10 hrs. Overhead: $250/day. Call Stipend: Paid on top of other payments when locum physician is covering call.	Working collaboratively with your clinic colleagues and utilizing locum services as needed are essential and sustainable ways of working. The 4-cut method uses 3-years of data, and therefore, occasionally relying on your colleagues and/or locum coverage will have no significant impact on your TPM payment.